		State of Maryla		cate of L			Reg. No.		
Physician	Decedent's Neme (First, Middle, Last)					2. Dete of De Month	ath Dey	Yeer	3. Time of Death
/Medical	Elizabeth	Schoppert				Septembe		999	11:10 P.M
Examiner	4a Fecility Name (If not institution, give	street and number)		4	b. City, Town, or t	ocation of Death	4c. County	of Deeth	
	Mariner Health of	Forest Hill			Forest	Hill	Har	ford	
Funeral	5. Sociel Security Number 6. Sec			Inder 1 Yeer	If Under 24 Hrs.	8. Dete of Bir (Month, Da	th	9. Birthpla	ace (State or Foreign
Director	216-05-9610	M % 92	Yrs. Mor	nths Deys	Hours Min.				
	Usual Residence of Decedent					Apr. 1	9, 1907	Mary	yland
M 18	10a. State 10b. County		city, Town or Location					10	d. Inside City Limits
or items 23e or 28e-f show miner must be notified at Funeral Director	Md Alleg	any	Western	port					No 2 No
be notified Director	10e. Street and Number		10	f. Zip Code			10g. Citizen of W	hat Count	ry?
0	311 Maryland Avenu	0		21562	,		*** 11 7	a	
era era		12. Was Decedent Ever in	U.S. 13 Wes F	21562		nacify Yes or No	United	State - America	
miner must	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2X No	If Yes,	specify Cuba	ispanic Origin? (S in, Mexican, Puert	Rican, etc.)	Bleck	k, White, e	
by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Y	es 2 No	Specify:		Specify:	Whi	te
			10. 0	11			100 100-1-100		
Completed	15. Decedent's Edu- (Specify only highest grade	cation e completed)	18a. Decedent's (Give kind of	of work done of	ation during most of wor f)	king	16b. Kind of Bu	siness/indi	ustry
G.	Elementery/Secondery (0-12)	College (1-4or 5+)			,	3.58			
3	Unknown		Homemak	er			Home		
Be	17. Father's Neme (First, Middle, Last)				18. Mother's Nan			B)	
2	John Lee				Nelli	e Watki	nson		
- 0	19e. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing Add	drass (Street a	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip (Code)
	Betty Sue Swisher/	Daughter	613 N.	Gate St	t. Abei	rdeen, M	D 21001		
	20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of	e)	Dete	20c. Location -	City or Tov	vn, State
	1 □xBurial 2 □ Cremetion 3 □ R 4 □ Donation 5 □ Other (Specify)					- 4 4	Keycor	TATK 7	
	21. Signature of Funeral Service License		neral Bapt	ist Ce	metery so of Facility	9/16/99	Keyser	, WV	
SQ.	21. Signature of Furieral Service Oceans		0			111 (Church S	t.	
	1. 10 ag	ne Non	Boal	Funer	al Home	Weste	ernport,	MD	21562
	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cetions that caused the dec	eth. Do not entar the	mode of dying	g, such es cardiac	or respiratory a	rrest,		Approximate Intervei Between
n									Onset end Deeth
ıl	Immediate Ceuse (Final disease or condition	Atheroso	lantic	Carl		1	50010	- 4	en your
r	resulting in death)	Due to	for es a consequence	cu/Bi	ovascy ic	(/ 4/	sease	1	CII Jear
9		200101	(or os a consequence	5 017.				1	
Examiner	Convention time and time	Due to	(or es a consequence	of):				1	
Exa	Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury	D00 (0)	(or es a consequence	9 Otj.				1	
	Cause (Diseese or Injury that initiated events							1	
edicai	resulting in death) Last	Due to (or as e consequence	of):				1	
		l							
an								l l	
/sic	Part II. Other significant conditions con	tributing to death but not re	sulting in the underly	Ing cause give	en in Pert I.	23b. Dld	tobacco use con	tribute to	the cause of deeth?
Physician/M						10	Yes 2 No	3 Prob	ably 4 Unknown
by									-
8							en eutopsy	24b. We	re autopsy findings ilable prior to
Completed						pend	rmed?	con	npletion of cause
Ē	the standard of								
						10	Yes 201No	1 🗆	Yes 2 No
Be	25. Was case referred to medical examiner?	le enitel.		Jan	26. Placa of Dea	ith (Check only	one)		
To	ILI TAS ZINI NO	lospital: 1 Inpatient 2	☐ ER/Outpatient 3[DOA Oth	4 by Nursing H	oma 5 ☐ Resi	dence 6 Othe	r (Specify)
::0	27. Menner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injun Won	at k?	28d. Describe	how injury occurr	ed	
atio	2 Accident Investigation		М		Yes 2 □ No				
Certification:	3 Sulcide 6 Could not be determined	28a. Piece of Injury - At I building, etc. (Spec	home, farm, street, fa	ctory, office		28f. Location (Street and Number	er or Rural	Routa Number,
9	2 101119-02	building, etc. (Spec	//			Ony or To	en, Siate)		
a	29e. Certifier 1 Certifying Phys	Iclan: To the best of my kn	owledge, deeth occu	rred at the tim	na, data and place	end due to the	cause(s) and me	nner as sta	ated.
edical	(Check only 2 Medical Examination)	ner: On the basis of examinend manner stated.	ation and/or investiga	ation, in my op	oinion, daath occu	rred at the time,	data and plece, a	ind due to	the cause(s)
Me	29b. Signeture and title of certifier			29c. License	number		29d. Dete signed	Month.	Dav. Year)
	20	010110	0 1			_			
	Man	y we	& MA	d	3552	2	Septemb	ver 1	4, 1999
Λ	30. Neme and address of person who co	mple of death (Ite	em 23a) (Type, Print)						,
A	Marilyn Wild, M	D 2 North	Ave. #101	Bela	ir, MD	21014			
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sign		-	6.1	_,,,,,			
istrar	SEP LAR	MAN MAN MAN	10	4577000	The same of the sa				

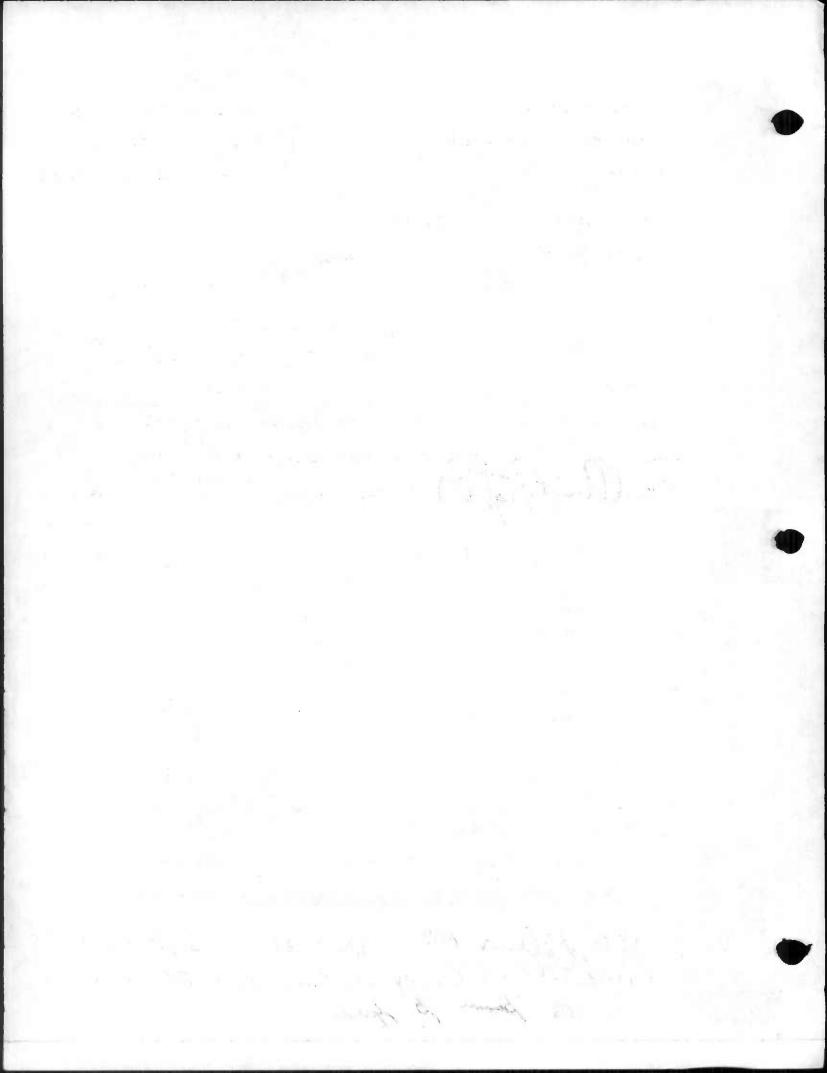
			. 10000	State of Ma	ryland /	Departme Certifica				giene	31502
			1. Decedent's Nama (First, Middla, La	st)					2. Dete of De		3. Time of Death
	Physici	an	Poulah Wingin	. Chama					Month	Day	Yaar
	/Medic		Beulah Virgin: 4a Fecility Nama (If not institution, giv					4b. City, Town, or	Location of Deet	nber 22.	
<i>)</i>	Examin	er	Garrett County		1 400	201					
	<i>r</i>		5. Social Sacurity Number 6. S		(In yrs. last b		ler 1 Year	Oaklar If Under 24 Hrs	8 Data of Bir	Garre	9 Birtholace (State or Foreign
	Funeral Director			□M 2√ F	89	Yrs. Month	s Days	Hours Min.	(Month, Da	v. Year)	9. Birthplace (Stata or Foraign Country) West Virginia
-			Usual Rasidance of Dacedant		0,7				rial. Z	+, 1910	west viiginia
	yland		10a. State 10b. County		10c. City, To	wn or Location					10d. insida City Limits
	Mar	to	WV Prest	on		Aurora					1 ☐ Yas 2 X No
	h the	je j	10e. Street end Number			10f. Z	Zip Coda			10g. Citizan of W	/hat Country?
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "naturel", or ferms 23a or 28a-f ahow avent, the Medical Examiner must be incitied a	Funeral Director	Rt. 1, Box 149					26705		US	A
	deat	ner	11. Maritei Status	12. Wes Decedent E Armed Forces?	ver in U,S.	13. Wes Dec	edant of h	dispenic Origin? (S an, Maxican, Puar	Specify Yes or No	- 14. Race	- American Indian,
2	or he		1 ☐ Naver Marriad 2 ☐ Married	1 ☐ Yas 2 ☑ No	0		2⊠ No		to nicen, atc.)		k, White, etc.
2	ours	by	3 N Widowed 4 □ Divorced	Year or Delas:		1 1 1 43	200140	эрвспу.		Specify:	White
5	72 h natu dica	Completed	15. Decedant's Ed (Specify only highast gra	lucation da complated)	16	a. Decedant's Us (Giva kind of v	sual Occup	pation during most of wo d)	rkina	16b. Kind of Bu	sinass/Industry
7	ithin Je.	dr.	Elamantary/Secondary (0-12)	Collega (1-4or 5-	-)			d)			
7	ygiel ygiel rt,		6th				Cook		delta a sala da	Cafeter	
	tal H	Be	17. Fathar's Nama (First, Middla, Last)						ma (First, Middla,		,
7	should be filed within 72 hours effer death with the Marylan and Mental Hygiene. Ind Mental Hygiene. Irrarked other than "naturel", or frems 23s or 28s-f show umatic avent, the Medical Examiner must be notified at	2	Alfred T.	White				Mamie			umb
_	. 6 6 2		19a, Informant's Name/Ralationship (and Number or R			
, U	of Health and I to the transfer of the Transfer of the Transfer tr		John E. Kerns/Sor	l				0, Auror			
5	it of t		20a. Mathod of Disposition 1 ☐ Burial 2 ☒ Cramation 3 ☐	Removal from Stata	cemet	of Disposition (Nery, crematory of	r other pla		Data		City or Town, Stata
	permit. Pages 1 and 2 Department of Health Important: If Item 27 I eny Injury or other tra page.		4 ☐ Donation 5 ☐ Othar (Specify		Omega	Cremat			9/22/99	Morgant	own, WV
2	Depar Impor eny In		21. Signature of Funeral Sarvice Licer	390				iss of Fecility ineral Ho	mo		
	00 = 0		Stalley 18-3	Klyson		32 S.	Seco	ond St.,	Oakland,	MD 21	550
			23a. Pert1. Enter the disease, or com shock, or heert feilure. List only	plications that ceused to one causa on each line	tha daath. Do	not anter tha m	oda of dylr	ng, such es cerdia	c or respiratory a	rrast,	Approximata Interval Between
Ī	hysician										Onset end Death
,	/Medical Examiner		Immediata Cause (Final disaasa or condition resulting in death)	. Acute	Intra	cerebra	al B	leed			5 Hours
		_	resulting in Gaath)					iovascu	lar Di	20260	Years
Т	g ti	Examiner		b. —	oscie	TOLIC (caru	TOVASCO	ital DI	sease	lears
	be axecuted ician and burief-transit	хаг	Sequantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury		ue to (or as a	consequance o	f):				
5	be assecuted sician and burief-transit	calE	ceusa. Entar Undarlying Causa (Disaasa or Injury	c							
200	phys the	edic	that initiated evants resulting in daath) Lest	D	ue Io (or es e	consequance of	f):				
40	ding ding	\$		d							
á	The law requires that the death certificate being by the attending physic page 2 should be detached for use as the b	Physician/M									
9	es that the dei igned by the a be datached f	1ys	Part II. Other significant conditions of	ontributing to death but	not rasulting	In the underlying	g ceusa giv	van in Part I.			stribute to the cause of death?
_	that hed b	by Pt	Hypertension	1					10	Yes 2X No	3 Probably 4 Unknown
3	n sign								24a. Was	an eutopsy	24b. Were eutopsy findings
3	w require been si should	ete	Past Ischemi	c Cerebr	al In	farcti	on		perfo	med?	available prior to complation of causa of death?
	e has	Completed							10	Yas 200 No	-1.2025
		0	25. Was cese referred to medical					oc Disea of Do			1 ☐ Yes 24 No
-	Physician: The la r this certificate he ral diractor, paga	0	axaminar? 1 ☐ Yes 2 🔀 No	Hospital:	t 2 ER/C	Outpatient 3 1	Oth	200	ath <i>(Check</i> only o Homa 5 ☐ Resi		as (English)
5			27. Manner of Death	28a. Data of Injury (Month, Day		Time of	28c. Injui			how injury occurr	
5	ding th. : Afte	를 다	1 Natural 5 ☐ Panding 2 ☐ Accidant invastigation		Yaar)	injury M		rk? Yes 2 ☐ No			
2	r dea ctor	flea	3 ☐ Sulcida 6 ☐ Could not be	28a. Place of Injur	y - At homa,	ierm, street, facto	ory, office				er or Rural Routa Number,
5	Dire	Certification:	4 Homicide	building, etc.	(Specify)				City or To	vn, Stata)	
	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funera		29e. Certifying Ph	ysician: To the best of	my knowledg	je, daath occurre	d at tha tir	ma, data and place	and dua to tha	cause(s) and me	nner es stated.
1	n 24 ne Fu	edical	(Check only 2 ☐ Medical Examone)	niner: On the basis of e end mannar state	exeminetion e ed.	nd/or invastigation	on, in my o	opinion, death occu	urred at tha tima,	data and plece, a	and dua to the causa(s)
	Toth	M	29b. Signature and title of certifier			2	9c. Licans	sa number		29d. Date signed	(Month, Day, Year)
			/ Jam/un	ins			D00	33464		9/22	199
	-	-	30. Neme and eddress of person who	completed ceuse of de	ath (Item 23a	(Type, Print)					-/
	2		Robert M. Couc				8. F	alon. M	W 267	16	
	Stat	te	31. Data filad (Month, Day, Year)	32. Registrar	's Signetura		1		4 4 U 1		
	Registra	ar	SEP 2 2 1	999	man	PA	Joor				

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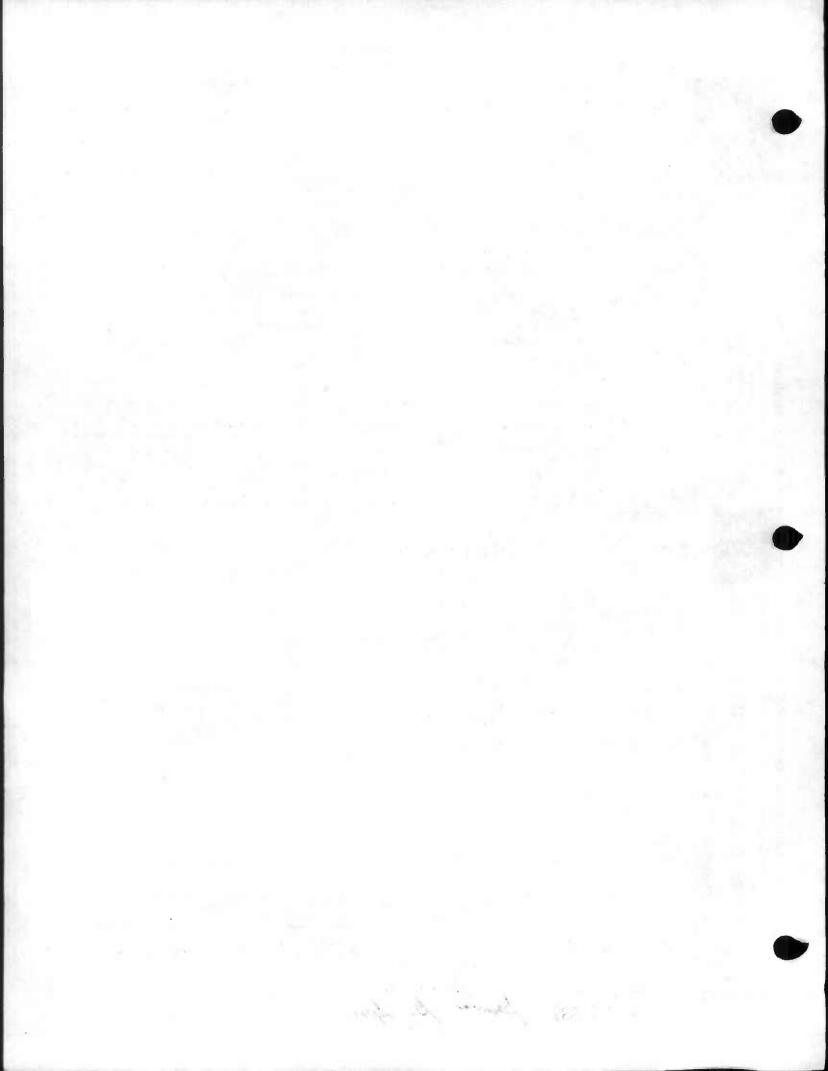
AND THE RESERVE AND STREET OF STREET Pay from the last

State of Maryland / Department of Health and Mental Hygiene

Facility Nama (If not institution	Stickler n, giva street and numbar, I Nursing Ce 6. Sax 1 M XXF 7. Ag 1 M XXF	enter ga (In yrs. last birth 89 Yr 10c. City, Town or Ridge. Evar in U.S. No 16a. C	monihs Days or Location Ley 10f. Zip Coda 2675 13. Was Dacedani of If Yas, specify Cub 1 Yas 2 No eccedant's Usual Occu sika kind of work done fe. Do NOT usa retire Schoolteach falling Addrass (Straa	4b. City, Town, or Locat Cumber lar if Undar 24 Hrs. 8. Hours Min. Se 53 Hispanic Orlgin? (Specify an, Maxican, Puarto Rick Specify: pation during most of working and) 18. Moiher's Nama (Fig. 18. Moiher) (Fig. 18. Mo	on of Daath nd Daia of Birth (Month, Day, Ya pt. 18, 10g. Yas or No- an, aic.)	4c. County of De Allec Allec 1910 9. B 1910 We Citizan of What C USA 14. Race - Arr Black, Wh Specify: Wh . Kind of Businas Ounty Bo ducation	1:00 A paih gany inithplaca (Stata or For Country) est Virgin 10d. insida City Li 1 Yas 20 Country? marican Indian, nita, atc. nite is/Industry pard of
Facility Nama (If not institution Cumberland Cocial Sacurity Numbar 36-60-0696 Ial Rasidanca of Dacadant Stata 10b. County WV Minera Street and Number Rt. # 2, Box Marital Siaius 1 Navar Married 2 Marria 3 Widowad 4 Divorced (Spacify only highas Iemantery/Secondary (0-12) Fathar's Nama (First, Middla, If James A. Hog Informant's Name/Reletionst James David Mathod of Disposition M Burial 2 Cramation Tation 5 Other (Sp	A Sax 1 M YAF AL 12. Was Dacedani Armed Forcas? 11 M YAF 12. Was Dacedani Armed Forcas? 14 M Yas, Giva Yaar or Datas: 15 Education 15 grada complatad) Collega (1-4or 2) Last) 19 Stickler 3 Bamoval from Stata pecify)	enter ga (In yrs. last birth 89 Yr 10c. City, Town or Ridge. Evar in U.S. No 16a. C	months Days or Location Ley 10f. Zip Coda 2675 13. Was Dacedani of If Yas, specify Cub 1 Yas 2 No eccedant's Usual Occu Give kind of work done fie. Do NOT usa retire Schoolteach failing Addrass (Straa	4b. City, Town, or Locat Cumberlar If Undar 24 Hrs. Hours Min. 8. Hours Min. Se This panic Origin? (Specify Specify: Pation Company of Working and Working and Maxican, Puarto Rick Specify: 18. Moiher's Nama (Formal Maxican) M. W.	on of Daath ad Daia of Birth (Month, Day, Ya pt. 18, 10g. 17as or No- an, aic.)	1999 4c. County of De Allec ar) 1910 We Citizan of What C USA 14. Race - Arr Black, Wh Specify: Wh . Kind of Businas ounty Bo ducation	gany Gany Gany Gany Gany Gard Gard
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al Rasidanca of Dacadant Stata 10b. County WV Minera Street and Number Rt. # 2, Box Marital Siaius 1 Navar Married 2 Marri 15. Decedant (Spacify only highas Idemantery/Secondary (0-12) Fathar's Nama (First, Middla, I) James A. Hog Informant's Name/Reletionst James David Mathod of Disposition Mathod of Disposition MBurial 2 Cramation 10b. County (Spacify Capacity Capacit	210 12. Was Dacedani Armed Forcas? 1	Evar in U,S. No 16a. D 19b. N Rt. 20b. Place of E camatary.	ar Location Ley 10f. Zip Coda 2675 13. Was Dacedani of If Yas, specify Cut 1□ Yas 2☒ No ecedant's Usual Occu Give kind of work done fie. Do NOT usa retire Schoolteach failing Addrass (Straa	53 Hispanic Origin? (Specifyan, Maxican, Puarto Rick Specify: pation during most of working ad) 18. Molher's Nama (Fig. 18. Molher's Nama (Fig. 18. W. W.	10g. Yas or No- an, aic.) 16b C E irst, Middla, Maid	Citizan of What C USA 14. Race - Am Black, Wh Specify: Wh . Kind of Businas ounty Boducation	10d. inside City Li 1 Yas & Country? merican Indian, nite, atc. nite sis/Industry pard of
Note that the second se	12. Was Dacedani Armed Forcas? 1 12 12 12 13 14 15 15 15 15 15 15 15	Ridge: Evar in U.S. No 16a. C. (6) 5+) 20b. Placa of C. camatary.	10f. Zip Coda 2675 13. Was Dacedani of If Yas, specify Cub 1 Yas 2 No ecedant's Usual Occu 3iva kind of work done fe. Do NOT usa retire Schoolteach	Hispanic Origin? (Specify an, Maxican, Puarto Rick Specify: pation during most of working ad) 18. Mother's Nama (Fig. 18. Mother's Nama (Fig. 18. W.)	Yas or No- an, aic.) 16b C E irst, Middla, Maid	USA 14. Race - Am Black, Wh Specify: Wh . Kind of Businas Ounty Bo	1 □ Yas 💥 Country? narican Indian, nita, atc. nite is/Industry pard of
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7		-	SACRED HEART H	OSPITAL				CUMBERLAN	ID .	ALLI	EGANY	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month Yeer **Physician** Kenneth Richard Tweed September 27, 1999 1:10 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 928 Mt. Nebo Road Chesapeake City Cecil If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Under 1 Yee 5. Social Security Number 7. Age (In vrs. last birthdev) Birthplace (Stete or Foreign Country) **Funeral** Months Deys 1 X M 2 □ F Yrs 222-22-2772 Delaware **Director** 60 November 26,1938 Usual Residence of Decedent Pages 1 end 2 should be filled within 72 hours after deeth with the Maryland nent of Heelth and Mentel Hygiene. 10a. Slete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or flame 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 928 Mt. Nebo Road 21915 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Brandywine oith and Mentel Hygiene. 27 is marked other than "I of traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Construction Company 12 Superintendent / Partner 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George T. Tweed Dorothy E. Chambers 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Heelth and Hitem 27 is m Kathleen M. Tweed 928 Mt. Nebo Road, Chesapeake City, Maryland 21915 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other placa) 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State West Chester, September permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris Company, Inc. 28,1999 Pennsylvania 21. Signature of Funeral Service Libense 22. Name end Address of Fecility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequenca of) attending ph the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 XYes 2 □ No 3 Probably 4 Unknown by 24b. Were autopsy findings avelleble prior to completion of cause Completed 24a. Wes an eutopsy Deed pege 2 s 2 10 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Physicien: director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2.K ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Attending 1 Naturel 5 Pending investigation deeth. 1 Yes 2 No 2 Accident ector: in by the 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) after 4 Homicide Hospital or 24 hours at Funeral D etely filled is 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi Medical 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number who completed cause of deeth (Item 23a) (Type, Print) 30. Name and address of person # 104, Elkton, MD 21921 ax 111 32. Registrer's Signeture 31 Date filed (Month, Dev. Year) State Registrar SEP 2 8 1999

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene

				Otato	or wary	ialia /	Certifica		Death	i wona i	Reg. No	-	2 0	10	UD
			1. Decedent's Name (First, Middle,	Last)						2. Date of			Vana	3. Time	of Death
г	Physicia /Medica		Irina Marjatta	Thomas						Month 5 40 /	un be	- 25	Yeer 1999	13;	30
	Examine		4a Facility Neme (If not Institution,		rumber)				4b. City, Town, o			c. County			
1			528 Old Elk Nec	k Road					North E	ast		Cecil			
	Funeral		5. Social Security Number	6. Sex		yrs. last b	oirthday) If Un Month	der 1 Yeer	if Under 24 H	rs. 8. Date of				ace (State	or Foreign
н	Director		N/A_	1□ M 2⊠ I	F		Yrs.	Deys	Se	ptember			Delav		
	p .	-	Usual Residenca of Decedent 10a. State 10b. County		10	o City To	wn or Location						144	Ord Boroldo	Oh . I lee's
	aryla	_	Toa. State Too. County		10	c. City, 10	wn or Location						10		City Limits
	New Trans	20	Maryland Cecil		N	orth									5 220110
	vith t	Director	10e. Street and Number				10f.	Zip Code			10g. Ci	tizen of V	What Count	iry?	
	ath v	Funera	528 Old Elk Nec			1.110		901		(D 17 - M			State		
	er de	Ľ,	11. Marital Status	Armed	Decedent Ever Forces?	r in U,S.	13. Was De	pecify Cub	Hispanic Origin? an, Mexican, Pu	erto Rican, etc.)	N0-		a - America ck, White, e		
20	s aft	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes,	es 2 📉 No Give or Detes:		1 ☐ Yes	2 🗓 No	Specify:			Specify	". To d	7 /174.	
21215-0020	filed within 72 hours after death with the Maryland Hygiene. "natural", or items 23a or 28a-f show ant, tra Madical Examiner must be northad at	8	15. Decedent's		Detes.	16	a. Decedent's U	suel Occu	nation		16b b	Cind of Bu	1am1	1/Whi	rte
15	in 72 in ne	Completed	(Specify only highest	grade complete			(Give kind of life. DO NO	work done	during most of v	vorking	100.1	1110 01 00	101110001110	uony	
212	filed within Hygiene. other then	E	Elementery/Secondary (0-12) N/A	Colleg	e (1-4or 5+)		N/A					N/A			
P	be filed withintal Hygiene. In other than event, it a	Be C	17. Father's Name (First, Middle, L.	ast)			11/11		18. Mother's N	leme (First, Midd	de, Maide				
a	id be ental ked o ic eve	108	Inigo J. Thomas						Anne Ma	arjatta	Vain	ikka			
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tra M	-	19a. Informant's Name/Reletionshi	p (Type, Print)		19	b. Mailing Addr	ess (Stree	and Number or				Stete, Zip	Code)	
			Inigo J. Thomas	/ Fath	er	5	28 014	Elk N	eck Roa	d North	Fact	Mar	vlano	1 219	01
ē,	te Her Her othe		20a. Method of Disposition		2	Ob. Place	of Disposition (/	Vame of		Date	20c. L	ocation -	City or To	wn, State	
E	Peges nent of I nrt: If He iry or o		1 M Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		OIII State		iew Cem		БСРС	ember 27,1999	Ray	Vio	тл Ма	rv1 a	nd
Baltimore,	nit.		21. Signature Juneral Service D		1	Day V			ess of Facility	,21,333.	Day	VIE	w, IIa	.I y I a	iid.
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		+	23a. Part1. Enter the disease, or c	omplications th	at caused the	death. Do			Main St			East	, mary	Approxim	
	Physician		shock, or heert feilure. List o	nly one ceuse o	on each line.									Onset end	etween
):	/Medical		Immediate Cause (Final	11	. t.	. /	()	411	2. Cert				i	2 41	6
1	Examiner		disease or condition resulting in death)	e/	en /Vic	colores	r repl	a()	refect						1
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	tificate be executed gphysician and es the burial-transit	Examiner	Sequentially list conditions	b	Dule	to (or es	a consequence (of):							
o,	an ar rial-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										i		
68760,	ysici	edicai	Cause (Disease or Injury that initiated events resulting in death) Last	C	Due	to (or as a	a consequenca o	of):							
	E 00	_	resulting in death) Last										1		
Box	eath certifical ettending pl	S		d								-			
	deat se eff ed fo	Physician/M	Part II. Other significant condition	s contributing to	o death but no	ot resulting	in the underlyin	g cause gi	ven in Part I.	23b. D	id tobacc	o use co	ntribute to	the cause	s of death?
P.0	by the	Ž.								1	☐ Yes	2/No	3 Prob	ably 4[☐ Unknown
	on of the de	2								_			,		
Records,	v requires that the de been signed by the should be detached	8									as an auto	opsy	ava	ere autopsy	r to
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Ä	The law requires that the death certata has been signed by the ettending page 2 should be detached for use	Completed								11	□ Yes 2	No	1 [Yes 2	□No
Vital		a)	25. Was case referred to medical						26. Place of D	Deeth (Check on	ly one)		1		
† <	S S D	0	examiner?	Hospital: 1	☐ Inpatient	2 ER/0	Outpatient 3	DOA O	her: 4 Nursing	Home 5 R	esidenca	6 □Oth	er (Specify	1)	
Jou	g Physical distribution of the second distributi		27. Manner of Death	28e. De	ete of Injury Youth, Day Ye	28b	. Time of Injury	28c. Inju	ry et	28d. Descrit	oe how inju	ury occurr	red		
0	eth. r: Aft	atio	1 Neturel 5 ☐ Pending 2 ☐ Accident Investiga	tion	rollin, Day 10	.,	M		Yes 2□No						
Division	er da	Certification:	3 ☐ Suicide 6 ☐ Could no determin	ed 286. Pl	aca of Injury - uilding, etc. (S	At home,	farm, street, fac	tory, office		28f. Location	n (Street a Town, Stat		er or Rura	Route Nu	ımber,
Ö	a after of in ordinate of in	9				,,,,,						1			
	L hour uner uner	edical	29a. Certifier Certifying (Check only Medical E	Physician: To	the best of my	y knowledg	ge, death occurr	ed at the ti	me, date and pla	ica, and due to the	he ceuse(s	s) and me	inner as st	eted.	a/e)
	To the Mospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	8	one)	and m	hataranaa		-								
	To To	Σ	29b. Signature end/title of cartifier	1.				29c. Licen	se number		29d. D	ate signe	d (Month, L	Day, Year)	
			+ far	Then,	つり			1)	15 5	14	sepi	tub	425	,199	5 9
	0		30. Name and address of person w	no completed c	ause of deeth	(Item 23a) (Type, Print)	1 11		- 11 -	•				
			I teures, Mo	VNAL	NoThe	n 61	- supert	1/2 //c	spice, C	Iklon,	MI)			
	State Registra	e r	29b. Signature end/title of cartifier A. Jav 30. Name and address of person w Fewler, M 31. Date filed (Month, Day, Year) SEP 2 8 1999	Maren 32	2. Registrar's	Signature	park	,							

THE R. LEWIS CO., LANSING MICH.

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 15,1999 3:06PM Shashi Prabha Thapar /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Prince George Cheverly | Nov. 19, 1947 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 India Days 1□M 2□F Months 098-44-3739 51 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1□Yes 2□No Directo Maryland Prince George Lanham 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5802 Lawton Ct. 20706 United States 11 Marital Statue 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yas 2 No
If Yes, Give
Yaar or Dates: 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Asian Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Librarian MD State Archives 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Ram Chand Soni Pushpa Lata 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Namita Chaudhary/Daughter 4810 Waltonshire Cr. Olney, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Northern VA. Crematory 9/18 Arlington, VA. 22. Name and Address of Facility Arlington Funeral Home.21. Signature of Funeral Service Licensy 3901 N. Fairfax Dr. Arington, VA. 22203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximate Interval Betw Onset and Death Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) Examine BLUNT DONE DUSURY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nas 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation SUISTELL SHOTAM NEDTON. FOUND 9-17-29 13:201 1 Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5636 ANNAPOLIS RA PRINCE GEORGE VETERINARY HOSPITAL 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBEN 4, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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e Hospital or Attandi n 24 hours after daeth e Funeral Director: A

To the Hosp within 24 ho To the Fune completely fi

filled in by

Funeral

Director

than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

pernit. Peges 1 and 2 should be filled within 72 hours attar c Department of Heelth and Mental hygiene. Interportant: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Empirements.

Physician /Medical

Examine

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P.O. Box 68760.

Records,

Division of Vital or Attending Physician:

Baltimore, Maryland 21215-0020

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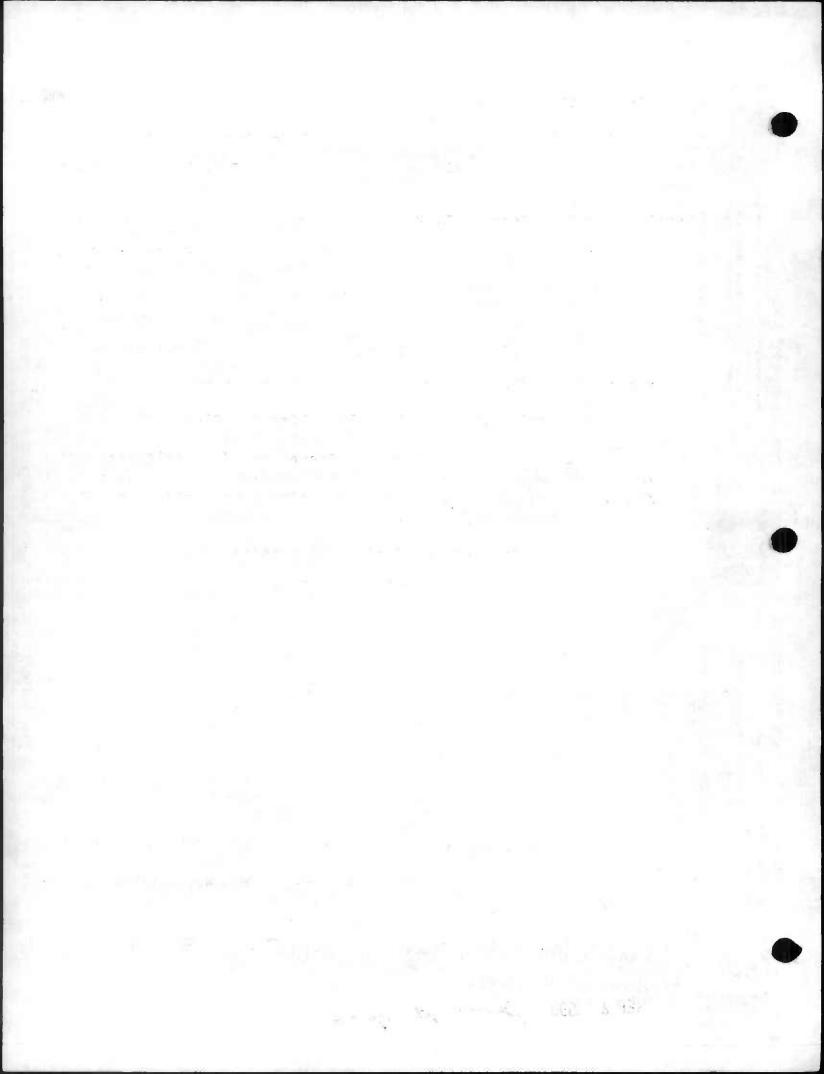
1 My Drums 31. Date filed (Month, Day, Year) State SEP 2 1 1999 when our 32. Registrer's Signature

111 Penn Street, Baltimore, Maryland 21201

Registrar

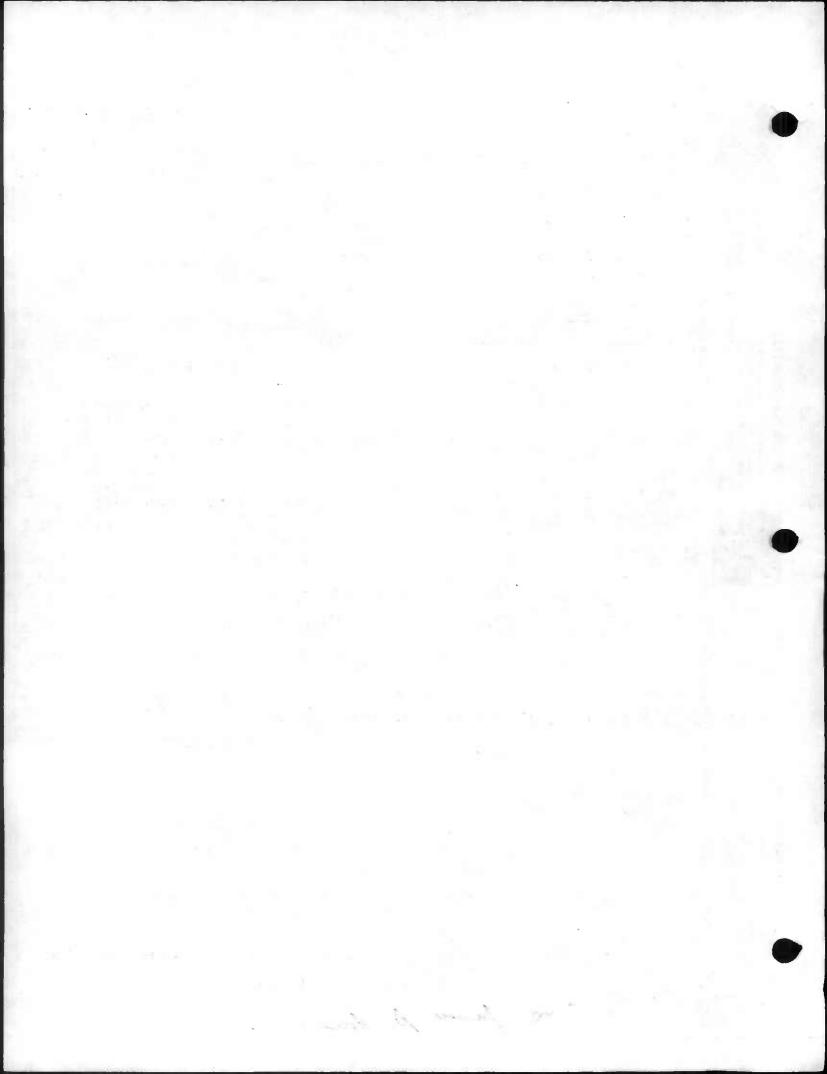
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	AMEND	ITEM: #3 PER MEO G/76 10-28-9 Certificate of Death	lental Hyg	iene	31508
	Physician	1. Decedent's Neme (First, Middle, Last) Nirwan Tilak Thapar	2. Date of Deal Month Septem	Dev	3. Tima of Death 1:20 5:25 P
	/Medical Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or Lo 5636 Annapolis Rd. Bladens	burg	4c. County	of Death ce Georges
L	Funeral Director	5. Social Security Number 5 0 4 − 58 − 0 3 6 9 1 M 2 F 7. Age (In yrs. last birthday) 6. Sex 1 Months 7. Age (In yrs. last birthday) 6. Tyrs. 1 Months 1 Min. 1 Min.	8. Date of Birth Month, Day, Jan.	Ž̃6″, 193	9. Birthplaca (State or Foreign 8 Country) India
	filed within 72 hours after deeth with the Maryland thygiene. ther than "natural", or items 23s or 25s-f show not, the Medical Evantier must be notified as not. Completed by Funeral Director	10a. Stete 10b. County 10c. City, Town or Location Maryland Prince George Lanham 10e. Street and Number 10f. Zip Code	1	Og. Citizen of W	10d. Inside City Limits 1☐ Yes 2☐ No /hat Country?
	23a o	5802 Lawton Ct. 20706		United	States
020	burs after deeth with the Marylar safe, or thems 23a or 28a-f show Examinar must be nothled at by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Sive Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I Yes, Give Yeer or Detes:	ecify Yes or No- Rican, etc.)		- American Indien, k, White, etc. - Asian
21215-0020	ges 1 and 2 should be filed within 72 hours aft it of Heelth and Mental Hygiene. If item 27 is marked other than "natural", or or other traumatic event, the Heates Francor or other traumatic event, the Heates Francor Other traumatic event, the Heates Francor or other traumatic event, the Heates Francor or other traumatic event, the Heates Franco	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 5+ Doctor	ing	16b. Kind of Bu	
Maryland 3	permit. Peges 1 and 2 should be filed within Department of Heelth end Mental Hygiene. Important: if Nem 27 is merked other than any Injury or other traumetic event, ma Monce. To Be Comp	17. Fether's Neme (First, Middle, Last) Prakash Chand Thapar Ratta	n Devi		
Man	2 should bend Meria la marks raumatic	19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rura 19b. Meiling Address (Street and Num			
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tim	Partition	4 Donetion 5 Other (Specify) Northern VA. Crematory	9/18	Arlin	gton, VA.
Bal	permit. Departri	Mukul Duylu 3901 N. Fairfax	Dr. A	rlingt	eral Home. on, VA.22203
	Physician /Medical Examiner	23a. Per1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac of shock, or heart feiture. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) Gunshot wound of neck, cutti			Approximete Intervet Between Onset and Deeth
	5	Due to (or as a consequence of): to neck and right shoulder			1
o,	be axecuted sicien and burial-trensit	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or trijury c.			t
Box 68760,	at the death certificate be axecuted to by the attending physicien and etached for use as the burial-trensit Physician/Medical Examir	Cause (Disease or thjury that initiated events resulting in death) Last Due to (or es a consequence of):			
	the atterned for hed for	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.	23b. Did to	bacco use con	tribute to the cause of death?
s, P.O.	es that the digned by the be detached by Physical by		10 Y	es 20XNo	3 Probably 4 Unknown
Records,	aw requires seen so 2 should pleted		24a. Wes a perform		24b. Were eutopsy findings evailable prior to completion of cause of death?
a B			t y ⊋ Ye	es 2 No	1 1 Yes 2 □ No
Vital	Physician: The this certificata ral director, per TO Be CO	25. Wes case referred to medical examiner? 1XT Yes 2 No Other: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing House			
of	Physical discension of the To	27. Menner of Deeth 28a. Dete of Injury 28b. Time of 28c. Injury at	me 5 LI Reside 28d. Describe he	21	- Occinc
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Division	safte al Direct				PM NE GED NESCO
	he Hospi in 24 hou he Funer pletely fill edical	29e. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a complex of examination and/or investigation, in my opinion, death occurred and menner stated.	and due to the co	ause(s) end me ate end place, a	nner es stated. and due to the cause(s)
	To the common of	29b. Signature and title of certifier 29c. License number OCHE			(Month, Day, Year) USEN 21, 1999
	50/	30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) HANGO A. KONEW 111 Penn Street, Baltimor	re, Mary	land 21	.201
	State Registrar	31. Date filed Month, Rey Year) 99 37. Registrar's Signature		7-	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of IVI	aryiariu		rtificate of	Death		Reg. No.		31509
	61		1. Decedent's Neme (First, Middle, La.	st)					2. Dete of De	ath Dev	Yaer	3. Tima of Death
7	Physicia /Medica	_	BERTHA MAE TRU	JE								2335 p.m.
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	B & 11	- 1-	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	r 25a-f show notified at	ò	MARYLAND ALLE	GANY	FR	OSTB	IIRG					W Yes 2□No
	or 28s	2	10e. Street and Number				10f. Zip Code			10g. Citizen of V	/hat Count	lry?
			48 TARN TERRA	CE			21532	2		USA		
	erns er m	runeral	11. Marital Status	12. Wes Decedent Armed Forces?		13. \	Wes Decedent of h	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race	- America	
Maryland 21215-0020	ors alf. o	à	1 Never Merried 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Detes:	No		1□Yes 2Ã No			Specify		ITE
50	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation da completed)		16a. Deced	dent's Usuel Occup	pation during most of worki d)	ing	16b. Kind of Bu	siness/Ind	ustry
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an		0 28	JOHN EVANS					JENNY &			0,	
ž	ahoul mark ment	=	19e. Informent's Neme/Reletionship (Type, Print)		19b. Meilir	ng Address (Street	end Number or Rura			Stete, Zip	Code)
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Ĕ	Page int: if	-	12 Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specifi					RIAL PAR		CUMBER	LAND	, MD
Baltimore	pemit. Departri Importa any inju		21. Signature of Funeral Service Licen	400)	H		IAPEL OF				
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2	rs after death. al Director: After t	5	4 ☐ Homicide determined		c. (Specify)	a, ram, ou	out, routory, omico		City or To			
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only one) (Check only one)	ysician: To the best niner: On the basis o end manner si	f examinetion	edge, deeth	occurred et the ti	me, date end place, oppinion, deeth occurre	and due to the ed et the time,	cause(s) end me date end plece, o	nner es st and due to	sted. the ceuse(s)
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	wi	7	30. Name and address of person who	ampleted cause of c	leath (ttem 2	3a) (Type.	Print)	- 1 00 /		Septem	ber_/	1)1999
	Store		Chana Oh M . N 31. Dete filed (Morlin, Day, Year)	5. 48 Ta	rn Te	rrac	e Fro	stburg	ME	Septem 215	32	
	State Registra			00 6	and spinors	A	1.					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 34 4b. City, Town, or Location of Death | 4c. Cou Myrtle 750 Edith Taylor 4a Facility Name (If not institution, give street and number) 4c. County of Death Fallston General Hospital Fallston Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M 20XF 87 213-58-0160 May 4, 1912 North Carolina Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Harford Forest Hill 10f. Zip Code 10a Street and Number 10g. Citizen of What Country? Apt. C 1624 Michelle Ct. 21050 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married 1 Yes 2♥ No Specify: Specify: White 3K Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John C. Church Jennie Fender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. E. Kelly Taylor, Jr. (Son) 1624 Michelle Ct., Apt. C, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩XBurial 2 Cremetion 3 Removel from State Harford Memorial Gardens 9/28/99 Aberdeen, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Furgetal Service Licenses 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Aberdeen, Maryland 21001-3399 Approximate Interval Between Onset and Death Immediata Cause (Finel disease or condition resulting in death) Yes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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"natural", or Items 23s

Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other treumstic event, the Mentel and page.

the Maryland

death

21215-0020

altimore, Maryland

P.O.

Records,

Division of Vital or Attending Physicien:

Examiner Physician/Medical been signed by the a should be detached þ Completed director, B Certification: To this funeral Affer To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

25. Was case referred to medical

5 Pending

6 ☐ Could not be determined

investigation

1□ Yes

27. Manner of Death

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

4-BNetural

28a. Date of tnjury (Month, Day Year)

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 20 No 26. Place of Deeth (Check only one)

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Cecitiving Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certified 29c. License number

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Hospital Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

use of death (Item 23a) (Type, Print)

29d. Dete signed (Month, Day, Year)

Be) an 31. Date filed (Month, Day

State Registrar

Medical

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				State of r	viaryianu /	Certificate of			g. No.	3	1511
	Dh i - i		1. Decedent's Name (First, Middle	le, Last)				2. Data of Death Month	1	Yaar	3. Time of Death
	Physici Medio/			MARIE BI	RANNOCK	TREGO		Septembe:			0200
	Examir		4a. Facility Nama (If not institutio	n, give street and number DICE HOUSE	er)		4b. City, Town, or L Easton	ocation of Death	4c. County o		
Н	Funeral		5. Social Security Number		Age (In yrs. last b	oirthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey,		9. Birthp	lace (State or Foreign
400	Director		219-34-3453 Usual Residence of Decedent	1□ M <u>255 F</u>	90	Yrs. Months Days	Hours Min.	Oct. 6	1908	Mary	
	fand was		10a. Stata 10b. County		10c. City, To	wn or Location				10	Od. Inside City Limits
L	the Maryla 28a-f sho notified at	tor	MD Doro	chester		Cambridge					TAYAS 2 No
3	0 138 0 138	Director	10e. Street and Number			10f. Zip Code		10	g. Citizan of Wi		try?
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Baltimore, Maryland 21215-0020	urs after de al', or hams Examiner n	by Funeral	11. Marital Status 1 Never Married 2 Man 3 Widowed 4 Divorced	If Vac Give	sy Z No	13. Was Decedent of H If Yes, specify Cubin	dispanic Origin? (Sp an, Mexican, Puerto Specify:	acify Yas or No- Rican, etc.)	14. Raca Black Specify:	, White,	
2-0	72 hours natural', Scal Exa	ted	15. Deceden	nt's Education est grade completed)	168	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation	ion 1	6b. Kind of Bus		
21	man r	Completed	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. DO NOT use retired	d)	ing			
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lan		To Be	Edward	Carroll	Bran	nock		rgaret	Bramb	-	
ary		۲	19a. Informant's Name/Relations	ship (Type, Print)	19	b. Mailing Address (Street	and Number or Rui	el Route Number,	City or Town, S	State, Zip	Code)
2	B # 12 # 2		Hubert C. Trego	o, Jr so	n	409 Bayly Av	e. Cambri	dge MD 2	1613		
ore	ges 1 a 1 of Hear If Rem or othe		20a. Method of Disposition	3 Demoval from Sta	20b. Placa cemet	of Disposition (Neme of ery, crematory or other pla	се)	Date 2	Oc. Location - C	City or To	wn, State
Ë	P S T T T		4 Donation 5 Other (S			rinity Churc	hyard 9-	24-99 C	hurch C	reek	, Md.
Bal	Depart Depart Import any in		21. Signature of Funeral Servica	Licensee	-2.	22. Name and Addre	Tr	omas Fun oridge MD		ome P	PA
			23a. Part1. Entar the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death. Do	not enter tha mode of dyir	ng, such as cerdiac	or respiratory arre	st,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	1. +	-A 0.	0- 00182	ation 0	22 + 0	.0		Onset and Death
	Examiner		disease or condition resulting in death)	a. 1000	Due to (or as a	La CONSEI	orany a	san la	iluxe	1	3-4 WUS
ч	D #	Iner		- Centar	coslo	votice Com	orany a	eten a	issoe	1 7	5 years
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	death	sicie	Part II. Other significant condition	ona contributing to death	but not resulting	in the underlying cause give	ven in Part I.	23b. Did tot	oacco use cont	tributa to	the cause of death?
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ds,	signe d be	d b			00000	100		24e. Wes an	autonsy	24b. We	ere eutopsy findings
Division of Vital Records,	The law requires that the death certifute has been signed by the ettending page 2 should be deteched for use a	Completed	·					perform		cor	allable prior to impletion of ceusa death?
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of \	2 00	၉	1 □ Yes 🔊 No	Hospitel: 1 Inpe			4 Li Nursing Inc	me 5 Resider	-		Hospiec
no	Iling After fune	tion	27. Menner of Death SNatural 5 ☐ Pendir 2 ☐ Accident investi	19	Dey Year) 28b.	Time of 28c. Injury Woo	ryat rk? Yes 2 □ No	28d. Describe how	w Injury occurre	ed	4
/isi	Attending or death. octor: After by the fune	fica	3 ☐ Sulcide 6 ☐ Could	not be	Injury - At home, f	farm, streat, factory, office	163 2 10	28f. Location (Str.		r or Rura	I Route Number,
á	s efter	Certi	4 ☐ Homicide determ	building,	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	Stete)		
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical Certification:	29a. Certifier (Check only one)	ng Phyaician: To the bes Examiner: On the basis and manner	of examination a	ge, deeth occurred et the tir nd/or Investigation, in my o	me, dete and place, opinion, deeth occur	and due to the car red at the time, de	use(s) end man te and place, ar	nner as st nd due to	eted. the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifie	-0		29c. Licans	se numbar	29	d. Date signed	(Month,	Day, Year)
		1	Xuneu	ue 0 (30)	lan l	MUZ	27409		4.2	2.0	77
			30. Name and address of person	who completed cause of	f death (Item 23e)	(Type, Print) Lawrer	EASIC	han, M.D.	10 8	216	01
	Sta Registr		31. Date filed (Month, Day, Yeer) SEP 2		strar's Signeture	B. Span	K				
			V == 1	4							

			Cer	uncate c	of Death	7		leg. No.		
I. Decedant's Name (First, Middle, La Willie Vaugh							2. Data of Dee Month	Day	Year	3. Tima of Dec
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e Fecility Neme (If not institution, given 12100 Ballina		er)					hington			eorge's
		Aga (In yrs. last i	birthday)	If Under 1 Ye		r 24 Hrs.	O Date of Birth			0
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Jsuel Residance of Decedent										0
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aryland Prince (George's		F	t. Was	hingto	n				1 🔼 Yes 2
0e. Street and Number				10f. Zip Coo	a		1	log. Citizen of	What Coun	try?
12100 Ballina Co	ourt			2	0744			Unite	d Sta	ates
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1 Navar Married 2 Married	1 ☐ Yes 2 If Yas, Giva	XNo		□ Yas 20X				Specif	73.7	
3 NWidowad 4 □ Divorced	Yaer or Dete									
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12th 7. Father's Nama (First, Middla, Last	t)			Mech		her's Nam	na (First, Middla,			
Haywood Vaugl							ry Etta			
19a. Informant's Name/Ralationship		4	9h Mailin	n Addrage /Ch	eet and Num		rel Routa Numbe			Coda)
Shirley Gilmore							Ft. Was			20744
Oa. Mathod of Disposition		20h Place	of Dispos	sition (Nama o	f		Data	20c. Location		wn, State
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4 ☐ Donation 5 ☐ Other (Special Service Lice		Koose	_	Memor			9/23/99	Chesar	reake,	, VA
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State Registrar

DHMH 16 Rev 6/95

Physi /Med Exan

Directo

permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at

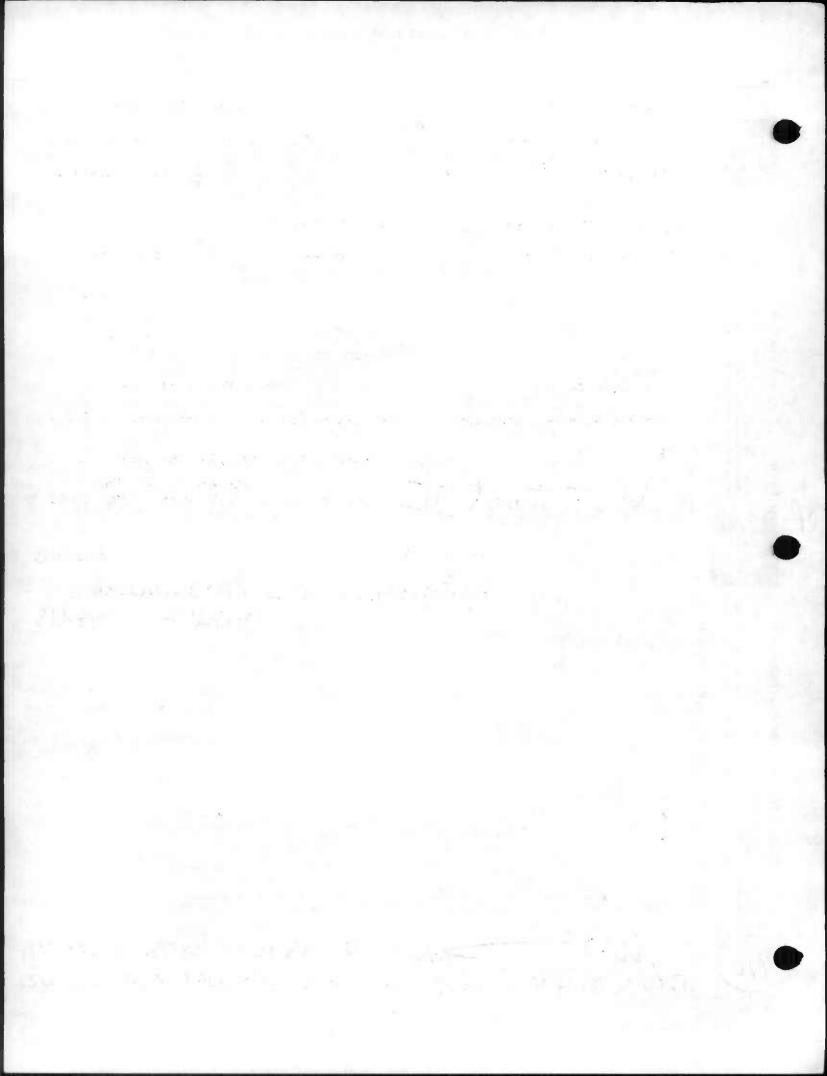
Physicia: /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

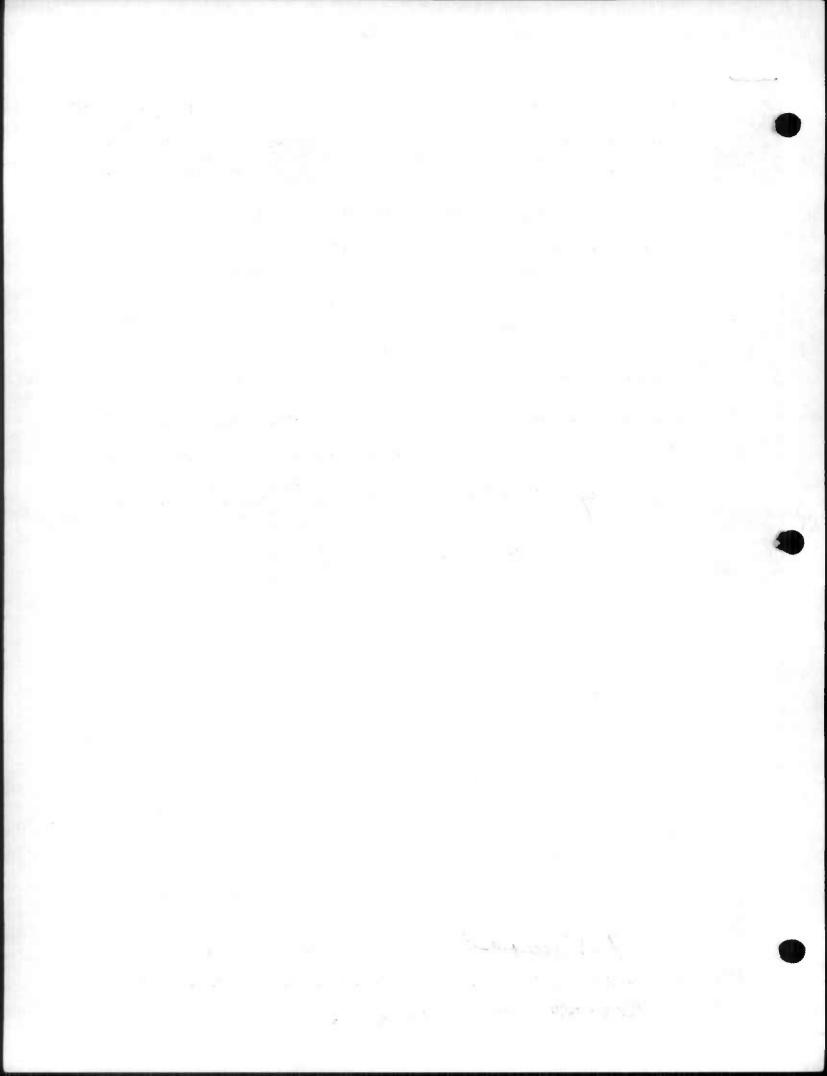
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene

,				,	C	ertifica	ate of	Death	F	Reg. No.			
Physici	an	Decedent's Neme (First, Middle, L EDGAR	ast) A.		TYAT	ZIPD			2. Dete of Dee Month	Dey	Year		of Deeth
/Medic	cal	4a. Facility Neme (If not institution, g		and a	WALE	CEK	1	4b. City, Town, or	SEPTEMBI		1999	6:10	AM
Examir	ier	7610 Norman		<i>01)</i>					Location of Death	4c. County			
Funeral		Social Security Number 6.		Age (In yrs.	lest birthd	ay) If Und Month	ler 1 Yaa s Deys			Prince		rge 's placa (Steta ntry)	
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and w		Usuel Residenca of Decedent 10a. Steta 10b. County		10c. Cit	y, Town or	Location					1	0d. Inside	City Limi
r 28a-f show	tor	Md.	P.G.	Ca	pitol	Heig	hts						s 2 N
3a or 28a	Funeral Director	10e. Street end Number 909 Minna Av	re.			10f. 2	Zip Code 20	743		U.S.A		ntry?	
permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itams 23a or 28a-f show stay injury or other traumatic avant, the Medical Exacting I must be notified at anne.	þ	11. Maritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1∕2 Yes 2 If Yes, Give Yeer or Data	159-1		3. Was Dec if Yes, sp		Hispanic Origin? (S ben, Maxican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Rac Ble	e - Amaricock, White,		
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within ene. then	Completed	Elementary/Secondery (0-12)	College (1-4	or 5+)	life	B. DO NOT	use retir	ed)	King .				
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ould be i Mental I arked or atic ava	To Be	Edgar M. Walke							ellie Nic		10)		
should and Men s marke umatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. M	eiling Addre	ss (Stree	et and Number or Ru	ural Route Numbe	r, City or Town,	Stete, Zip	Code)	
and 2 balth a n 27 is		Alma Pollard/Sis	ter		120	2 Nye	St.	,Capitol	Hgts.,Md	. 2074	3		
Peges 1 nent of He int: If Itan		20a. Method of Disposition XX Buriel 2 □ Cremetion 3 4 □ Donation 5 □ Othar (Space			emetery.	sposition (A cremetory of and Ve	other of	ns Cem.		20c. Location - Chelter			
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or Attendent Siter deat Diractor: In by the	Certification:	2 Accident investigation 3 Suicida 8 Could not 4 Homicide determined	00- 51	Injury - At he etc. (Specify	ome, ferm,				28f. Location (Si City or Town	treet end Numb n, Stete)	er or Rura	l Route Nu	mber,
To the Hospital within 24 hours of the Funeral I completely filled	edical (29e. Certifier (Check only one)	nysician: To the be miner: On the basis end menner	or exemina	wledge, de ion end/or	eth occurre Investigation	d et the t	ime, dete end plece opinion, deeth occu	, end due to the corred et the time, d	euse(s) end me ete end place,	enner es st end due to	ated. the cause	(s)
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1:/		30. Neme and eddfess of person who	completed courses	of death /lea-	23e\ /T	Print\	MD	20459	SE	PTEMBEI	22,	1999	
IVa		DR. ANTHONY ARCEN					STRE	ET NW. WA	SHINGTON	DC 20/	122		
Stat	_	31. Dete filed (Month, Dey, Year) SFP 2, 2, 199	32 Regi	strer's Signe		. 10	~ .						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death Physician ESTHER ELIZABETH WALLACE SEPTEMBER 10,1999 7:05PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7100 EMMA CT. FORT WASHINGTON PRINCE GEORGES 5. Social Security Number 7. Age (In vrs. lest hirthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 4, 1935 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 X F WASHINGTON DC Director 578-44-8250 63 Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD PRINCE GEORGES TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4107 LYONS ST 20748 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Armed Forces?

1 Yes AM No
If Yes, Give
Year or Dates; Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: BLACK p 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mentel Hygiene Important: If item 27 is marked other the eny injury or other traumatic event, that page. CUSTODIAL FED GOVT 17. Father's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Sumeme) Be PETER JONES ESTHER TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) BEATRICE T. WALLACE / DAUGHTER 7100 EMMA CT. FORT WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 Cremation 3 Removel from State 9-17-99 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY CLINTON, MD 22. Name and Address of Fecility
ALEXANDER S. POPE FUNREAL HOME 21. Signature of Emeral Service Lice 2617 PENN. AVE S.E. WASHINGTON DC 20020 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure and only one cause or each ine. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a ACUTE MYOCARDIAL INFARCTION Examiner Due to (or as a consequence of): DILATED CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) HYPERTENSION AND CORONARY ARTERY DISEASE Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown INSULIN DEPENDENT DIABETES, CHRONIC HEPATITIS C by 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) DAUGHTERS Yos 2 No Other: 4 Nursing Home 5 Residence 6 NOther (Specify) RESIDENCE Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or Attendit within 24 hours after deeth. To the Funeral Director: A completely filled in by the fu

State Registrar

FRANCYNE ANDERSON M.D. 31. Dete filed (Month,

6492 LANDOVER, MD 32 Registrar's Signature

end address of person who completed cause of death (Item 23a) (Type, Print)

D19459

SEPTEMBER 16.1999

the Manyland

death

r than "natural", or home 23s or 28s-f show the Medical Exempler must be notified at

"natural", or items

physician end the buriel-transit

US0 25 for use as

signed by t

peed page 2

certificate

this funeral

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director

The law requires that the death certificate be executed

Box 68760,

P.0.

Records,

Division of Vital Attending Physician:

if Hygiene. Other then "natural", or her

Baltlmore, Maryland 21215-0020

Sign of 2 136

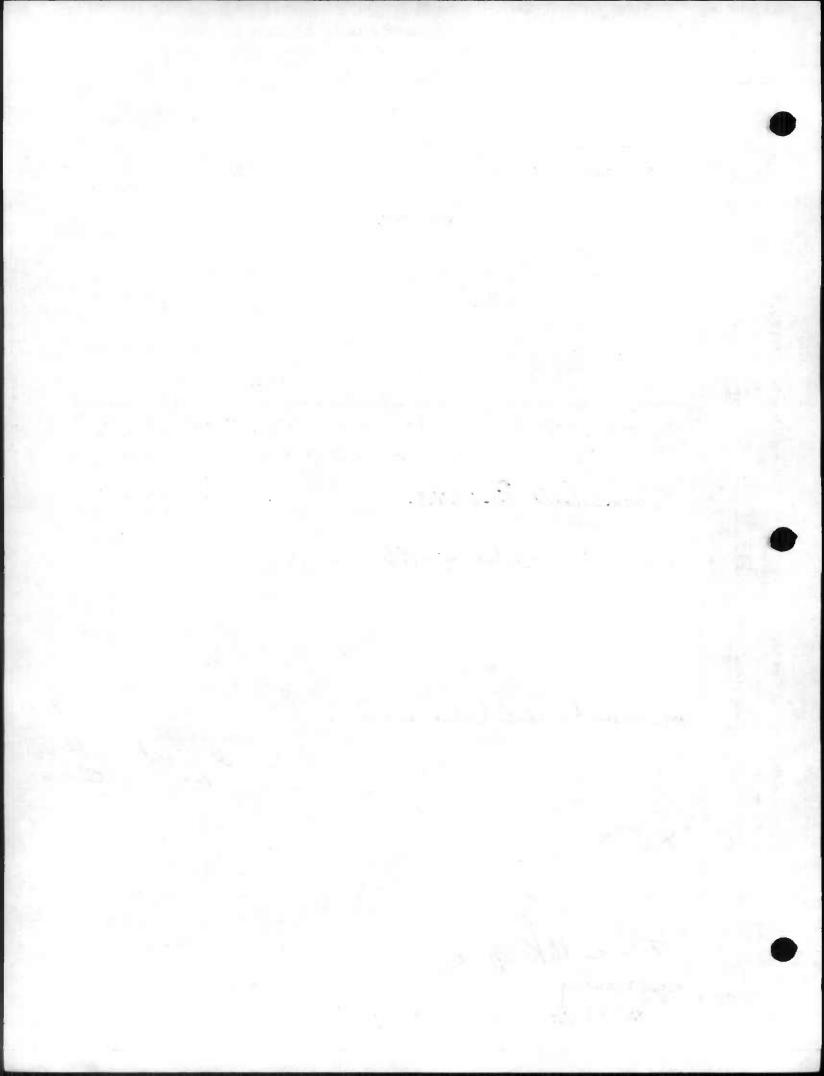
State of Maryland / Department of Health and Mental Hygiene

		otato ot mary		Certifica	ate of l	Death	F	Reg. No.	2	11010
	1. Decedent's Name (First, Middle, La.	st)					2. Date of Dea	ith	Vees	3. Tima of Death
Physician /Medical	Anna Rachel Walto	n					Sept.	23 1	999	9:45 AM
Examiner	4a Facility Neme (If not institution, giv	e street and number)			4	b. City, Town, or Lo	cation of Death	4c. County	of Death	
	Harford Memorial	Hospital			H	avre de (Harf		
Funeral Director	5. Social Security Number 6. S 219-44-8898 Usuel Residence of Decedent	DH OFF	yrs. last birtl		der 1 Year ns Deys	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Mar. 30	Year) , 1910	9. Birthpl Count Vorth	lace (State or Foreign try) Carolina
land was	10a. State 10b. County	100	. City, Town	or Location					10	0d. Inside City Limits
Many Many to to	Maryland Harfor	d H	lauro	de Grad	0.0					1 X Yes 2 □ No
or 28a-f a be notified	10e. Street end Number	u 11	iuvice (Zip Code			10g. Citizen of V	Vhel Coun	try?
		d.			21078			USA		
D ther death v there 23s siner, must Funeral	11. Marital Status	12. Was Decedent Ever	in U,S.			ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		e - America	
02(02(3 ₩ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:			pecify Cuba 2 Ø No		rican, etc.)	Specify	White, white, whit	
1 21215-0 ad within 72 ho vygiene. her than "naturn it, the Medical I	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16e. l	Decedent's Us	sual Occup	ation during most of work ()	ing	16b. Kind of Bu	siness/Ind	lustry
Ma Ma	Elementary/Secondary (0-12)	Coilege (1-4or 5+)				0				
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yland yland Mental H Mental H minked oth	17. Father's Name (First, Middle, Last)					18. Mother's Name		Maiden Suman	10)	
C INTERNATION OF					10	Cora Co				
Maryland Maryland Maryland of 2 should be the th and Mental Hy T is marked other traumatic event.	19a. Informant's Name/Relationship (and Number or Run				
	Willie B. Walton 20a. Method of Disposition					le Rd., H		Grace,		
altimore, Mary mit. Pages 1 and 2 about partment of Health and M portant: If then 27 is near y injury or other traumal as.	1 Buriel 2 Cremation 3	nemoval from State		Disposition (A						
tim Pa	4 Donation 5 Other (Specification)		Dublin				9-25-99	Darling	ton,	Maryland
Ball Ball Ball Ball Ball Ball Ball Ball	21. Signature of Funeral Service Licer			D T	Tant	ss of Facility d Funeral	Home,	P. A.		
	23 Part1. Enter the disease, or com shock, or beart failure. List only	olloations that caused the	death. Do n	ot enter the m	ode of dyin	g, such es cerdiac	or respiratory er	rest, MV	21911	Approximete Interval Between
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/Medical	Immediate Cause (Final			0					İ	14-11
Examiner	disease or condition resulting in death)	a	10 /01 26 2 0	onsequence o	come	lia			- 1	years
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O. D. Be day	Part II. Other significant conditions of	ontributing to death but no	t resulting in	the underlying	g cause giv	en in Pert f.	23b. Did t	obacco use co	ntributa to	the cause of death?
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cords, P.O. Box 68760, vequires that the death certificate be assecuted been signed by the attending physician and should be detached for use as the bunal-transiteted by Physician/Medical Examileted by Physician/Medical Examile							24a. Was a	an autopsy	ava	ere autopsy findings alleble prior to
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G at stage of							1 🗆 Y	res 2∭No	10	Yes 2 No
Vital Rec Vital Rec i certificate has to director, paga 2 s	25. Was case referred to medical examiner?					26. Plece of Deat	h (Check only o	ne)		
of Vita Of Vita Physician: this certific rial director,	1 Yes 2 No	Hospitel: 1 Inpatient	2□ ER/Out	patient 3		4 U Nursing Ho	me 5 Resid	lenca 6 🗆 Oth	er (Specify	v)
On of on of ding Phys After this funaral of	27. Menner of Deeth 1 ⊠Natural 5 ☐ Pending	28a. Dete of Injury (Month, Day Yes	28b. Ti	ime of jury	28c. Injur Wor	y at k?	28d. Describe h	ow Injury occur	red	
Sio sio	2 Accident investigation			М	10	Yes 2 No				
Division of Division of Italian or Attending Para Silvector: After Ideal in by the funant Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (Sp	At home, far sec <i>ify)</i>	m, street, fact	ory, office		28f. Location (S City or Ton	Street and Numb m, State)	er or Aura	I Route Number,
Vital Ours as I Ce										
Division of Vita Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funaral director. Medical Certification: To Be (yalcfan: To the best of my liner: On the basis of exer and manner stated.								
To the I within 2 complet	29b. Signature and title of cartifier	and mainer stated.		2	29c. Licens	e number		29d. Dete signe	d (Month.	Dav. Year)
F 3 F 8	Dadstan	M.D.								
	30. Name and eddress of person who	KASH 7	(Item 23a) (lype, Print)	IL Rd	0047813 . Swile 2	00 B.	lar r	1) 2	1014
State	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	,						
Registrar	SEP 2 4 1999	serenas &	. 40	rocks	•					

Walter Mitchell Whalen

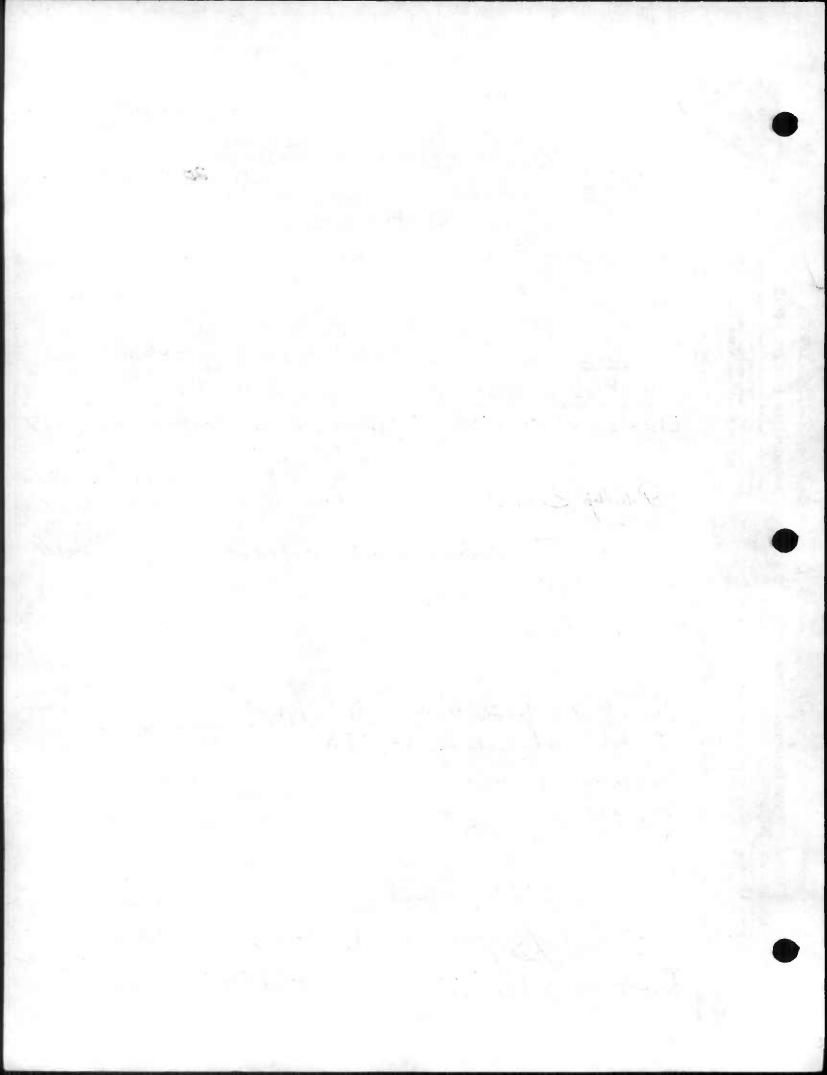
State of Maryland / Department of Health and Mental Hygiene

	AMEND I	TEMC. #22 DADE	T DED MES	G-Cer	lificate of	Death		ng. No.	0.10
		TEMS: #23 PART 1. Decedent's Name (First, Middle, La		G//7"			2. Dete of Deat	h	3. Time of Death
b	Physician /Medical	WALTER	MITCHELL	WH	ALEN		Month Septemb	Day Year Der 21. 1999	10:05 P.M
	Examiner	4a Facility Name (If not institution, give	e street and number)			4b. City, Town, or L		4c. County of Death	
		6001 Goodfellow D			Millodas I Van	Suitland		Prince Geo	
	Funeral Director	5. Social Security Number 6. S 219-16-1583 Usuel Residence of Decedent	7. Age (In yrs	s. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, 2/12/27	Year) 9. Birthp Count ST MAI	placa (Stete or Foreign http). R Y COUNTY
	bu & m	10a. Stete 10b. County	10c. C	City, Town or Lo	cation			1	0d. Inside City Limits
	Maryland and show illed at	DC N/A	W	ASHINGT	ON				1√ Yes 2 No
	vim the Ma t or 28a-f s be notified Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of What Coun	itry?
	23s Marth	2044 36TH ST SE			200			USA	
21215-0020	72 hours after death with the Maryla natural, or teams 23e or 28e-f show Scal Examiner must be notified at sted by Funeral Director	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1. Yes 2 No if Yes, Give Year or Dates:	AKMYI	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Sp ben, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Raca - Americ Black, White, Specify: BLAC	etc.
20	ed within 72 ho typiene. wer than "naturn it, the Medical.) Completed	15. Decedent's Ed (Specify only highest gra	ducation	(Give i	ent's Usual Occu	during most of work	ina	16b. Kind of Business/Inc	Justry
121	Man Man	Elementery/Secondary (0-12)	College (1-4or 5+) NONE	life. D	O NOT use retin	9d)		US GOVERNME	ZMTP
	Hygie Hygie ant, th	8TH GRADE 17. Father's Name (First, Middle, Last)		PUSTAL	EFIFLUII	18. Mother's Nam	a (First Middle N		214 1
lan	id be il in	CHARLES WHALEN					A JENNIE		
Maryland	shou ment ment	19a. Informant's Name/Relationship (Type, Print)	19b. Meilin	g Address (Stree	nt end Number or Rur	el Route Number,	City or Town, Stete, Zip	Code)
	and 2 lealth a m 27 le her tra	GAIL L. RUFFIN (I	AUGHTER)	6001	GOODFELI	LOW DRIVE,	SUITLAN	ID, MD 20746	5
Baltimore,	Department of He Department of He Important: If New Inty Injury or oth Itios	20a. Method of Disposition 1 X Bunial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State		sition (Neme of netory or other plants L CEMET)			20c. Location - City or To SUITLAND, MI	
Balt	Departi Departi Imports any Inju	21. Signeture of Funeral Service Umm	By #CC02		. Name and Addr	JOL		INES CO., IN	
		23a. Part1. Enter the disease, or com	plicetions that caused the dea	ath. Do not ente	or the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	0			Onset and Death
x 68760,	entificate be executed ding physicien and sa as the burist-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consequ	uenca of):	GLEROTTO	CARDIC	OVASCULAR	DISEASE
8	The law requires that the death certific cate has been signed by the ettending p page 2 should be detached for use as Completed by Physician/Me						1		
0	the day the achec	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause g	iven in Part I.		bacco use contribute to se 2 □ No 3 □ Prof	
e,	oned to det	the rection we there	oschute Croha	muchen	Inene			2010 00110	and a find the first of the fir
ğ	en sig buid b	,					24a. Was ar		ere autopsy findings ailable prior to
ecc	as be 2 sh						Sue.	~ / CO	mpletion of cause deeth?
E =	E sag S						1 Ye	s 2 No	yes 2□ No
VIT 9	ysician: The last certificate hadirector, page	25. Was case referred to medical examiner?	Unanitat.			26. Place of Deat			D- 11-1
Division of Vital Records, P.O. Box	her thinneral	1 🕅 Yes 2 🗆 No 27. Manner of Death Natural 5 🗆 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	ury at ork?	ome 5 Reside 28d. Describe ho	nce 6XXOther (Specifi w Injury occurred	Residence
ivisio	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:		U	home, farm, stre		Yes 2 No	28f. Location (Str City or Town	reet end Number or Rura , Stete)	Il Route Number,
	pital o burs af miled in	29a. Certifier 1☐ Certifying Ph	valetas. Ta tha book of an ilu						
	Pun Fun etely		ysician: To the best of my kn niner: On the basis of examin and manner stated.	etion end/or inv	estigetion, in my	opinion, death occur	end due to the ca red et the time, da	ite end pleca, and due to	the cause(s)
	Me Me	29b. Signature and title of certifier	- /		29c. Licen	se number	29	9d. Date signed (Month,	Dey, Year)
	0	Theol U	King and			O.C.M.E.	S	September 22	1999
	(10)	30. Name and address of person who	completed cause of deeth (Ite			Stroot B-	ltimomo	Marriand 3	1201
	State	31. Date filed (Month, Dey, Year)	32 Registrar's Sign		reili S	pureer, Ba	теппоге,	Maryland 2	.1201
	Registrar	SEP 2 4 1999	Deros	A.	Somet.				



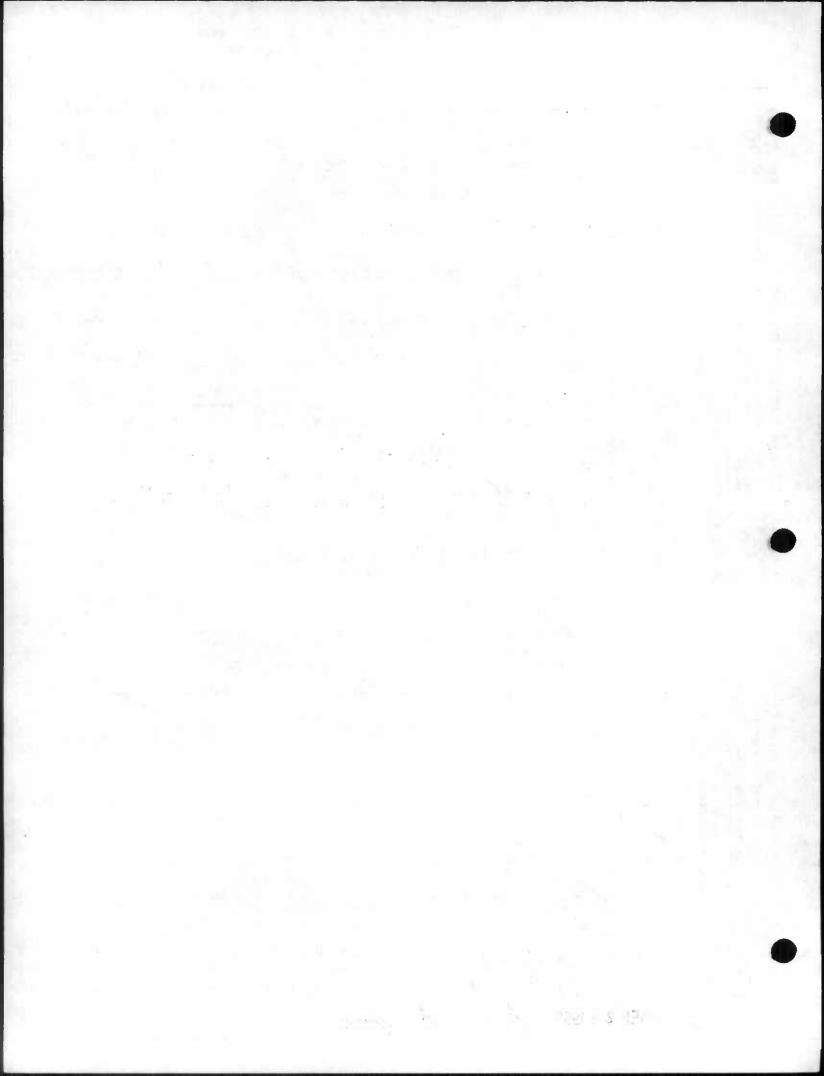
State of Maryland / Department of Health and Mental Hygiene

	State of Maryland	Certificate of Death	Reg. No.					
Physician /Medical	1. Decedent's Name (First, Middle, Last) Richard M. Wilson	Sept	te of Deeth New Year 4.39pm					
Examiner	4s Facility Name (If not institution, give street and number) Sinai Hoopi Fal	Baltim	of Death 4c. County of Death					
Funeral Director	5. Social Security Number 225 -34 - 244 6. Sex 12-M 2 F 7. Age (In yrs. last by 12-M 2 F 6. Sex 12-M 2 F 6.		te of Birth place (State or Foreign Country) 9. Birthplace (State or Foreign Country)					
show the dat	10e. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits 1-√2 yes 2 □ No					
or 23a-f sho be notified a	10e. Street and Number	101. Zip Code_	10g. Citizen of What Country?					
	2503 VIOLET AVE. 11. Marital Status 12. Was Decedent Ever in U.S.	21215	U, S, A,					
1020 ours after death val', or itsems 23 Examiner must	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 175 yes 2 No N Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yell Yes, specify Cuban, Mexican, Puerto Rican,	Black, White, etc. Specify: Black					
/5 m. 121215-0020 ed within 72 hours all popularia. er than "natural", or it, the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
		Retired Auto Mech. 18. Mothar's Nama (First,	Hutomotive Middle, Maiden Sumama)					
Maryland of 2 should be file in the and Mental by T is marked other traumatic event	Richard L. Wilson	Julie	. 1/ 1					
Son is and 2 showing the man 27 la m	19a. Informant's Name/Relationship (Type, Print) Charles Wilson (Brothy)	3808 Unleaded Route 3808 Unleaded Rd	Bastimore, MI 21218					
Rattmore, semit. Pages 1 s Seatment of He Important if Hen Important if He	20a. Method of Disposition 20b. Place	of Disposition (Name of Deta tery, crematory or other place) on Famy 14 Cen ctay 9-26	3-99 Kenbridge, Va					
Balt pamit. Depart impount impound imp	21. Signature of Funeral Service Licensee Pullip Bell	22. Name and Address of Fecility 5, P. 3	Jones + Son Funeral Home unbridge Va. 23944					
Physician	23a Part1. Enter the disease, or complications that ceused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac or raspin	retory arrast, Approximeta Interval Between Onset and Deeth					
/Medical Examiner	resulting in death)	ty o carolist Infaction a consequence oi):	n. suller					
), assected n end ie-transit Examiner	b	a consequence of):						
68760, filters be amouted as the burlet-transit edical Examir	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	211835100.20						
	resulting in death) Last d	a consequence of):						
P. K. P.O. BOX that the death carti od by the attending detached for use Physician/M	Part II. Other algnificant conditions contributing to death but not resulting	in the underlying cause given in Part I.	3b. Did tobacco use contribute to the cause of death?					
ds, P. res that the signed by be detected	Cheonic Teal I artem on 1) can	your, West Myhyt	1 Yes 2 No 3 Probably 4 Dunknown					
of Vital Records, P.O. Box (Physician: The law requires that the death cartificate has been signed by the attending ral director, page 2 should be detached for use a: To Be Completed by Physician/Mi	Dealete mellitim, unit olegen	la. Wes an autopsy performed? 24b. Wara autopsy findings aveilabla prior to completion of cause of death?						
Vital Relicion: The licion: The licions the contilicate he rector, page	25. Was case referred to medical	26 Plans of Death (Che	1 Yes 2 No					
of Vita	examiner? 11D Ves 2 No Hospital: 1 Inpatient 2 DENOutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
e n 82 E	27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of							
DIVISION (tal or Attending P ts after death. e) Director: After t ed in by the funer Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		cation (Street and Number or Rural Route Number, by or Town, State)					
DIVISIOR To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attending filled in by the furnity that furnity the furnity filled in Certification	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and manner stated.							
To the within To the comp	29b. Signature and title of certifier 29c. License number 29c. License number 29d. Datesigned (M)							
	30 Name and address of person who completed cause of death (Item 23a) 1. Deta filed (Month, Day, Year) 32. Registrar's Signature	8 GROEN FREE Ref Scit	keds, Bolt. AD					
State Registrar	SEP 2 4 1999	4. Somiti						



State of Maryland / Department of Health and Mental Hygiene 7 7 1 1 1 0

					,	Cert	ificate of	Death	R	eg. No.	aJ.	1310
	Dhiralai		1. Decedent's Neme (First, Middle, La	st)					2. Date of Deal Month	th Day	Year	3. Time of Death
	Physici /Medio		Rosemary Helen	n Weiss					Sept.		99	7:15 AM
	Examir		4a Facility Name (If not institution, giv	· · · · · · ·				6b. City, Town, or L	ocation of Death	4c. County	of Death	
1			12704 Blossom				Killedes & Vess	Bowie		Prince	e Ge	eorges
m	Funeral		5. Sociel Security Number 6. S	ПиаЖЕ	(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthp	place (State or Foreign ntry)
	Director		271-07-6916 Usuel Residence of Decedent	8	2	113.			oct, 1	7,1916	Ohi	.0
	dand dand		The state of the s							0d. Inside City Limits		
	Man H	to	Md. Prince	Georges		Bow	io					1 Yes 2 □ No
	286	Je l	10e. Street and Number	dediges		DOW	10f. Zip Code		1	0g. Citizen of W	hat Cour	ntry?
	ier death with the Marylan items 23s or 28s-f show ner must be notified at	a D	12704 Blossom Lane 20715 USA									
	de at	Completed by Funeral Director	11. Marital Status	12. Wes Decedent E	ver in U,S.	13. W		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race		can Indian,
21215-0020	\$ 6 E		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:	lo		Yes 2 1%No	Specify:	rican, etc.)		k, White, Wh:	
ဂ ၁	"natural",		15. Decedent's Ed (Specify only highest gra	lucation	1	6a. Decede	nt's Usuel Occup	ation during most of work	ina	16b. Kind of Bu	siness/Inc	dustry
7	C .		Elementery/Secondery (0-12)	Cottege (1-4or 5	+>	life. De	O NOT use retired	n di in di i				
7	il Hygiene. other than	S		2		Secr	etary			Manufa	-	ring
Maryland	S E D >	To Be	17. Father's Neme (First, Middle, Last)					18. Mother's Nem	e (First, Middle, I	Maiden Sumam	a)	
3	should be ind Mental imarked o		Paul F. Scheib						Bauer			
<u>a</u>	2 = = =		19a. Informant's Neme/Reletionship (,, ,		of other		and Number or Rur				
	1 and Health em 27 rther tr		Ann W. Kunz/Da	ugnter			4 BLOSS	om Lane				
saitimore,	40 mm 40 0		20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specific		Met	ropo mato:	Titan	×9) 09 -		Alexai Airgin		.a,
gail	permit. Page Department of Important: If i any injury or phice.		21. Signature of Funeral Service Licer Shannon W. B	Reall	700		Neme end Addre	В	eall Fu			
	_		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plicetions thet caused	the death. [Do not enter	the mode of dyir	. Crain	or respiretory em	est,	Ma.	20715 Approximate Interval Between
	Physician		SHOOK, OF HEAR FAILURE. CISCOTTY	One cause on eech an							1	Onset and Death
	/Medical		tmmediate Cause (Finel disease or condition	moto	15/7	1	Colu	LA			1	
	Examiner		resulting in deeth)		Due to (or es						1	
7	P 45	ine		b								
	and trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or futury)									
68/60,	oe exe	E E										
Ø	rificata be executed ng physician and as the bunal-transit	Due to (or es a consequence of): Due to (or es a consequence of):								1		
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DOX	iles that the death cer signed by the attendir d be detached for use	Physiclan/M										
9	the d	ıysi	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I.					23b. Did tobacco use contribute to the cause of death?				
_	that ded b	Y P						1 Yes 2 No 3 Probably 4 Uni			bably 4 Unknown	
ds,	requires	d by							24a. Wes a	n autopsy		ere eutopsy findings
2	- LD (0	ete							perfor		co	ailable prior to impletion of cause death?
necord	The law sata has b page 2 s	Completed								25/		
	cartificata rector, pag	S	25. Wes case referred to medicat					00 Pile 12	1 Y		11	Yes 2 No
NE SI		To Be	exeminer?	Hospitel:	M 20 ED	Outpatient	3□ DOA Oth	26. Place of Deel	th (Check only or ome 5 11 Beside	/	ne (C	6.11
5	Phys or this oral d		27. Menner of Deeth	28a. Dete of Injur	y 28	b. Time of			28d. Describe h			y/
DIVISION	Attending Firder of death. Peter: After by the funer	ig ig	1 Setural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office						28f. Location (Street and Number or Rural Route Number,			
2	Attend r death betor: by the	fice										
5	o after	Certification:	4 Homicide	bullding, etc	. (Specify)				City or Town	n, State)		
	To the Hospital or Attend within 24 hours after deat To the Funeral Director: completely filled in by the		29e. Cartifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.									
	in 24 he Fi	edlcai	(Check only one) 2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.									
	Vithi Comp	Σ	29b. Signeture and title of certifier	1)		29c. Licens	e number	, 2	9d. Date signed	(Month,	Day, Year)
			V (KIDD P) 11/4 20196 4/21/94									
	(12)	1	30. Nemerand address of person who completed cause of leath (Item 23a) (Type, Print)									
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Registra	r's Signeture		AA 7:-	1 77			1.0	. 1110011
	Registr		SEP 2 2 1999	Serve	1		souls!					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Month **Physician** September 19, 1999 Johnie Wilson 6:51PM /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Southern Maryland Clinton Prince George's If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** 1∏M 2□F Months 249-05-5433 89 Yrs. Director South Carolina May 25, 1910 Usual Rasidence of Deceden with the Meryland permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylan Department of Heelih and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 10h Counts 10c. City. Town or Location 10d. Insida City Limits 1 Ves 2 □ No Director Clinton Maryland Prince George'S 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 9106 Pineview Lane 20735 USA Funeral 13. Was Dacedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 2 ☑ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, 11. Marital Status Bleck, Whita, atc 1 ☐ Nevar Marriad 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: **Black** ð 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DD NDT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Saw Mill / Private Laborer 10th 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Be Joe Wilson Millie Robinson 19b. Meiling Address (Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Reletionship (Type, Print) Julius Wilson/ Son 2217 Newton St. NE Wash., DC 20018-3072 20b. Plece of Disposition (Nama of cametery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data W Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 9-24-99 Forest Hills Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility Marshall's Funeral Home of MD 4308 Suitland Rd. Suitland, MD 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarvel Between Onset end Death **Physician** /Medical Immediata Cause (Final 6 DAYS disaasa or condition rasulting in daath) Examiner In lococcus arrens Examiner ettending physician and for use as the burial-transit law requires that the death certificate be executed Saquantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use coptribute to the cause of death? detached the been signed by should be detac 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to complation of cause of death? Completed 24a. Was an autopsy performed' has nenn certificata 1 Tas 2/2 No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical axaminer? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA P 1□ Yes 2□ No funerel Data of Injury (Month, Day Year) Certification: 27. Manney of Deeth 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, daeth occurred et tha time, dete and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the best of my knowledge, daeth occurred et tha time, dete and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the best of my knowledge, daeth occurred et tha time, dete and place, end due to the causa(s) and manner stated. 29e. Cartifier Medical 29d. Date signad (Month, Day, Year) 29b. Signature and title of certifier 29c. Licansa number 20 30. Name and addrass of person who completed cause of daeth (Item 23e) (Type, Print) Deta filed (Month, Day, Yaar) 22. Registrar's Signature MD.20603 WOLDORF 31. Deta filed (Month, Day, Yaar) State SEP 2 2 1999 Registrar

State of Maryland / Department of Health and Mental Hygiene 1997

ASP				Certificate	of Dea	ath	Re	g. No.	W 1.4	/ La U			
	1. Decedant's Nama (First, Middle,	Last)					2. Data of Death		Year 3.	Time of Death			
Physician /Medical	TAMATER MATE	er, Jr.							1999 1	:30 A			
Examiner	An Contille blome /// med lendle dies	give street end number,)		4b. Cit	ty, Town, or Lo	ocation of Death	4c. County					
	PRINCE GEORGES	S HOSPITAL			CHE	EVERLY		PRINC	E GEORG	ES			
Funeral	5. Social Security Number	. Sax 7. A	ge (In yrs. last bi	Months		Inder 24 Hrs. ours Min.	8. Data of Birth	Year)	9. Birthplace	(State or Foreign			
Director	578-73-8134	1⊠M 2□F	12	Yrs.			(Month, Day, 0 1 0 7	57	Washir	igtori,			
P .	Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, Tow	m or Location					and to	side City Limits			
show										☐Yes 2☐No			
vith the Mai t or 28a-f s be notified	Maryland P.G.		Fores	tville	a ala		140			X			
di you	1808 Richie F	5col		10f. Zip 0			-10	10g. Citizen of What Country? USA					
firer death with the Manyland ritems 23s or 28s-f show the murt be notified at Funancial Director	1000 KHCIITE I	12. Was Decedant	Ever in U.S.			la Origina /Sa	noity Vac or No.		se - American Inc	den			
P 2 2	11. Marital Status 1 □ Navar Married 2 ☑ Married	Armed Forcas	?	13. Was Decede If Yes, specif	y Cuban, Me	exican, Puarto	Rican, atc.)		ck, Whita, etc.	anguri,			
020 urs aff		1 ☐ Yas 2√2 If Yas, Giva Yaar or Datas:	Ç40	1□ Yes 2l	XING Sp	ecity:		Specify	Blac	k			
15-0020 72 hours after Tratural; or the	15. Decedent's	Education	16a	. Decedent's Usual	Occupation		1	16b. Kind of Business/Industry					
1 21215-0 led within 72 ho hyglene. her than "natura it, the Medical	(Specify only highast Elamantary/Secondary (0-12)		5.1	(Giva kind of work life. DO NOT use	done during retired)	most of work	ing						
212 d withli plene.	12	College (1-4or	E1	.ectric	Tech.		7	raffi	c Sign	al Div			
be filed tal Hygid d other avent, Be Co	17. Father's Nama (First, Middla, La	ist)			18.1	Mother's Name	a (First, Middla, N	laiden Suman	na)	71111			
and Mental and Mental and Mental and Mental	Rudolph H. Wa	lker, Sr.	•		B€	ernett	a John	ison					
re, Maryland 21215-0020 s 1 and 2 should be filed within 72 hours at f Health and Mental Hygdene. Tem 27 is marked other than "natural", or other traumatic avent, the Medical Exam To Be Completed by F	19a. Informant's Name/Ralationship		198	. Mailing Address (Street and N	lumber or Run	al Routa Number,	City or Town,	Stata, Zip Code)			
and and a saith	Deborah Walker	/Wife		2609 Nicholson St. #204 Hyattsville									
Ore of Hear	20e. Mathod of Disposition PDBurial 2 □ Cramation 3	□ Removal from State	0.000.040	0b. Place of Disposition (Nama of comatery, crematory or other place) 20c. Location - City or To									
Pag mant ant: h		4 Donation (Specify) Glenwood Cemetery 3/23/99 Washint											
Baltmore, M pemit. Pages 1 and 2 Department of Health important: if item 27 is any injury or other tre page.	21. Signature of Funeral Service Lie	sensee		22. Nama end	Addrass of I	Facility							
D 88E58	1 CUL	Dunn & Sons 5635 Eads St. NE DC											
Physician /Medical Examiner	23a. Part1. Entar tha disease, or or shock, or haart failura. List or immediate Cause (Finel disease or condition resulting in death)		ead Ir	juries	of dying, su	ch as cardiac o	or respiratory arre	st,	friter	roximate val Between et and Death			
i i			Dua to (or as e	consequence of):					i				
swecuted in and rial-transit	Sequentially list conditions			1									
Exe	Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaasa or Injury		Dua to (or as a consequence of):										
certificate be swecuted ding physician and use as the burlal-transit	Cause (Disaasa or Injury that initiated evants rasulting in death) Last	Due to for as a consequence off:											
- pa -	rasulting in coatil) Last								i				
Box stendir for use		d											
O. B. death he stier hed for used for u	Part il. Other significant conditions	contributing to death b	out not resulting i	n the underlying cau	sa given in	Part I.	23b. Did tol	bacco use co	ntribute to the	cause of death?			
15, P.O. BOX res that the death ce signed by the attendi be detached for use by Physician/							1 🗆 Ye	s 20 No	3 Probably	4 Unknow			
\$ 50 A													
The lew requires to The lew requires to The lew requires to page 2 should be Completed by							24a. Was ar perform		available	topsy findings e prior to ion of cause			
Hes by ye 2 s									of death	?			
= F # 8 0							tø⊈va	s 2 No	1 25 Ves	2 □ No			
f Vital Rysician: The I secontificate his director, page		Biographot:				Place of Deet	Check only one	9)					
Of Vita Physician: this certific ral director,		Hospital:					ma 5 Reside						
DIVISION (Its or Attending Prise the death.) The time to the timers ind in by the timers Certification:	27. Mennar of Death 1 □ Neturel 5 □ Panding	28a. Data of Inju	y Yaar)		Work?		28d. Describe ho		uck by	Car			
DIVISION OF Attending offer death. Director: After Jin by the tune	2/Accidant investigat 3 Suicida 6 Could no	be one Blees of the	1	arm, street, fectory,	1 Yas	2 No	28f. Location (Str		/				
DIVISION Attendent destructions of the destruction	4 ☐ Homicida determine	building, el	c. (Specify)	,			City or Town	Stata) Rife	he Road	ta ivaniosi,			
Fillied C	29a. Certifiar 1☐ Certifying	Physician: To the best	of my knowledou	streel		to and alone	Capital 1	eights,	Md				
DIVISION OF To the Hospital or Attending Phywithin 24 hours effer death, within 24 hours effer death completely filled in by the funeral Medical Certification:		Physician: To the best aminar: On the besis o and mannar st	f axamination an	d/or Investigetion, is	ny opinion	, death occurr	ed at tha time, da	ita and place,	and due to the	ause(s)			
Me of the	29b. Signature and titla of certifier	with manner of		29c.	License num	nber	29	d. Data signe	d (Month, Day,	Year)			
F3F5	A.	200			C.M.E				ER 19,19				
(1)	30. Nama and address of person	Chull W	leath (from 02c)										
6	De was c	(1 1 .	N)		opp C	troot	Baltimo	ma Mas	C beelve	1201			
State	31. Data filed (Month, Day, Year)		rer's Signetura	111 1	CIIII 2	ueel,	DOT L'IIIO	Le, Mal	Y LOUIU Z	.1201			

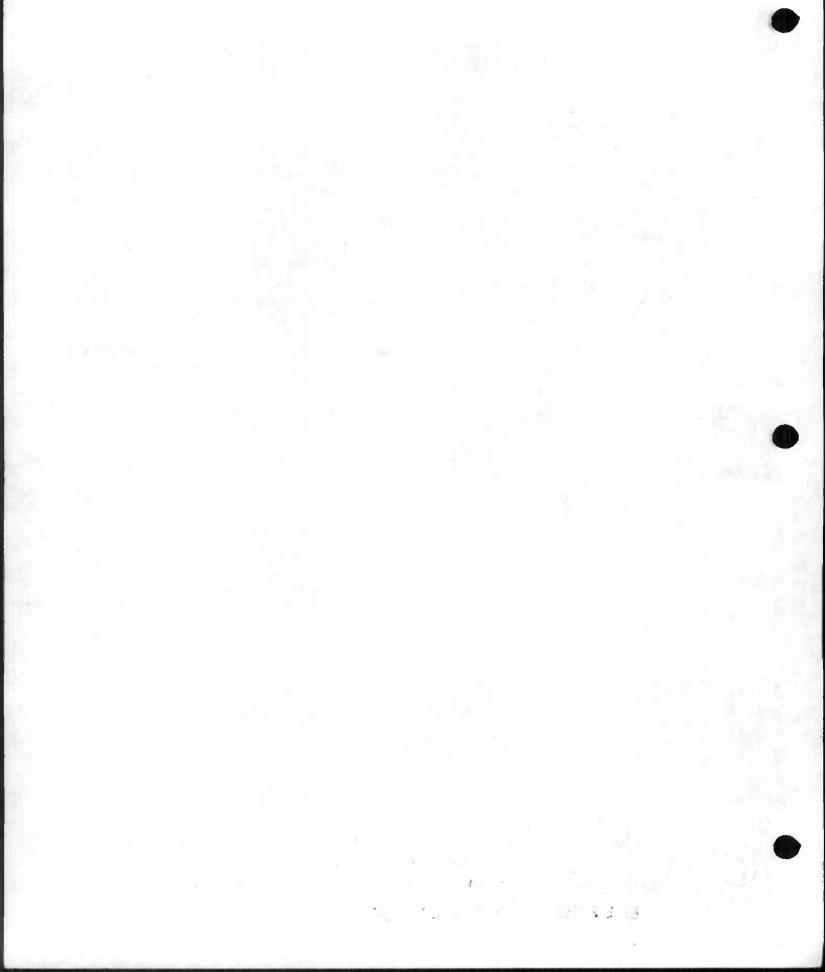
DHMH 16 Rsv 6/95

State

Registrar

SEP 2 2 1999

32. Registrer's Signetura



		Decedent's Neme (First, Midd	a, Last)			Ce	rtifica	te of	Dea	th	2. Dala of D	Reg. I	No.		3. Time of Death
Physici · /Medic			Whit1	LOW .							SEPTE:	MBEI	R 14,	1999	3:10pm
Examir		4a Facility Name (If not institution Layhill Nursir			imber)						r Location of Dea Spring	th	4c. County	of Death	
Funeral Director		5. Social Security Number 223-09-5865	6. Sax	2 🗆 F	7. Aga (In y	rs. last birthday) 81 Yrs.	If Unda Months	r 1 Yaar Days		der 24 H	rs. 8. Dete of B	av. Ya	917	Coun	laca (Stata or Foreign try) ginia
f show	or	Usual Rasidanca of Decedant 10a. State 10b. County Maryland Montgo			10c.	City, Town or Lo		ng						1	0d. Insida City Limits
noth	rect	10e. Street and Number					10f. Zi	p Coda				10g.	Citizen of V	What Coun	try?
23a o	a D	3227 Bel-Pre Rd	•				1.74	209	06		United S				es
of, or items 2	by Funeral Director	11. Marilel Status 1 Never Married 2 Mar 32 Nidowed 4 Divorced	ried	Was Dec Armed Fo 12 Yas If Yas, Gr Yeer or D	2 □ No		Was Dece If Yes, spe 1 Yas				(Specify Yes or N arto Rican, atc.)	0-	Blac	a · Amaricok, Whita,	etc.
Medical F	Completed by	15. Decedar (Specify only higher Elementery/Secondery (0-12)	st grade co	mplated)		16a. Dece (Giva life.	dent's Usu kind of wo DO NOT L	ork dona	durina i	most of w	vorking	Education		usinass/inc	dustry
or the	Com			Collega (5+		Pr	ofes	sor						ion	
and Mental Hy s marked oth umatic avent	To Be	17. Fether's Name (First, Middla, Martin Whit]							ame (First, Middle le Robi			na)			
permit: rages and a should be med within 72 hours after death win the maryina populment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumetic avent, the Medical Examinet must be notified at once.		19a. Informant's Name/Ralation: Gail Whitlow— 20a. Method of Disposition 1	Coope	r/Da	State 20t		3 Br	iarw ma of other pla	ood		Rochvil Deta 9/18/99	le,	Md.	2085 City or To	3
ysician Medical aminer	ner	Immediata Causa (Final disease or condition rasulling in death)	a			etast (or as a consec			Pr	vs+	ate,	ev	ene	er	Onset and Daath
hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Undarlying Cause (Disease or Injury Ihat Initiated avants resulting in death) Last	b			(or es a consec									
iding p	Me		d							<u> </u>					
ed by the attending phy detached for use as the	Physician/Medi	Pert II. Other significant conditi	ons contrib	uting to d	aath but not	asulting in tha u	ndarlying	ceusa gi	van in P	ert I.		d tobac	co use co	ntribute to	the cause of death?
been signershould be	Completed by										24a. Wa	s an au formed	utopsy ?	ev co	ara autopsy findings milable prior to mplation of cause daath?
ate has	mo										10] Yas	2 PNo	10	Yas 2□ No
ls certificate director, pag	Be	25. Wes casa rafarred to medica axaminar?	-							laca of D	eath (Check only	ona)			
this or	2	1 Yas 2 No	Hosp	10		☐ ER/Outpatie		UA		Nursing	Home 5□Re				y)
2 20		27. Manner of Deeth 1								2 🗆 No	28d. Dascribe				
Dire Dire	Certification:									City or T	own, Si	ata)		l Routa Number,	
within 24 hours To the Funeral completely filled	edicai	29a. Certifiar 1 Certifyii (Check only one) 2 ☐ Madical	g Physicia Examiner:	On tha b	asis of axam	nowledge, deat ination end/or in	occurred vestigation	at tha ti	ma, date opinion,	end pla deeth oc	ce, and dua to the curred at the time	e cause i, data	a(s) and mo and place,	enner as s and dua to	lated. tha cause(s)
2 9	end manner stated. 29b. Signatura end titla of certifiar. 29c. Licansa number 29d. Data									ata signed (Month, Day, Year)					

30. Nema and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

GUL CHABLANI M.D. 11119 ROCKVILLE PIKE, ROCKVILLE, MD 20852 31. Dete filad (Month, Day, Year) SEP 2 0 1999

State Registrar



		State of Maryla	nd / Department of Certificate of		al Hygiene Reg. No.	9 3	1522					
Physicia	1. Decedent's Neme (First, Middle, La				te of Deeth	Year	3. Tima of Deeth					
/Medica	al	Whitfield		Sep	tember 14	1999	5:11 P.M					
Examine				4b. City, Town, or Location		nty of Death						
<u> </u>	Sacred Heart Hos		last hirthday) If Under 1 Ye	Cumberland		legany						
Funeral Director		Sex 7. Age (In yrs	Yrs. Months Day	ys Hours Min. (Mi	te of Birth onth, Day, Year) r. 6, 1908	9. Birthi Cour Mar	place (Steta or Foreign ntry) Tyland					
B B 11	10a. State 10b. County	10c. C	ity, Town or Location			1	IOd. Inside City Limits					
May Mad	Md Allega	ny	Westernport				1X Yes 2 No					
	Md Allega 10e. Street and Number 212 Maryland Av	enue	10f. Zip Cod 215		10g. Citizen Unite	of What Cour	•					
	11. Merital Status 1 Never Married 2 Merried	12. Wes Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent C	of Hispanic Origin? (Specify Youban, Mexican, Puerto Rican,	(Specify Yes or No-							
	3 X Widowed 4 □ Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ N			Bleck, White, city: Wh	oite					
5-0 72 ho	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) Unknown	ducation	16a. Decedent's Usual Occ	cupation	16b. Kind o	f Business/In	dustry					
within within the same.	Elementary/Secondary (0-12)	College (1-4or 5+)		ne during most of working ired)								
d 2 Hygier ther th			Homemaker			me						
Vian Wental	17. Fether's Neme (First, Middle, Last, William Virts			18. Mother's Neme (First, Mary Herr		neme)						
	19a. Informant's Name/Relationship (Betty Johnson /			eet and Number or Rural Route and Ave. Wester								
Baltimore, semit. Pages 1 st bepartment of Hear mountaint if Illem my injury or other mass.	20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Localis cematary, crematory or other place)											
Daring Special												
D STEER												
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Indergring		or as a consequence of):	GHT UPPE	v Lobe		inknown					
be executed sician and burial-transit		Due to (or es a consequence of):			1						
- 0 50 6	Cause (Disease or injury that infalled events resulting in death) Last Part II. Other eignificant conditions of the con	Due to (or as e consequence of):									
BOX eath cent attending for use	O Control Office of the Control of t		4:		01 DIAA	1						
d by the Cottach	Part II. Other eignificant conditions of DU/mondvy		sulting in the underlying cause	given in Pert I. 2	1 Yes 2 N		o the cause of death'					
requir	Atrial flu	edem A		24	ta. Wes en autopsy performed?	ev	ara autopsy findings vailable prior to empletion of cause death?					
The lay	E				1□ Yes 200		□ Yes 2√ No					
sician: The certificate lirector, pag	25 Was case referred to medical			26. Place of Deeth (Chec			2100 1700					
	examiner?	Hospital: Inpatient 2	ER/Outpatient 3□ DOA	Other: 4 Nursing Home 5		Other (Speci	(v)					
Attending Physical death. ector: After this by the funeral di		28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. In		ascribe how injury oc							
UNISION Call or Attending P is after death. al Director: After the line of the funer.	3 Suicide 6 Could not b	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fectory, officing)		cation (Street end No ty or Town, State)	mber or Run	al Route Number,					
To the Hospital or After within 24 hours after de To the Funeral Direct completely filled in by the Madical Cartelists	29a. Certifier Check only (Check only one)	ysician: To the best of my known of the basis of axamino and manner stated.	owledge, death occurred at the ation and/or investigation, in m	tima, data and place, and du y opinion, daath occurred et th	a to tha cause(s) and he time, data end pla	mennar as s ce, and dua t	stated. o the causa(s)					
within To the comp	29b. Signeture and title of certifier		29c. Lice	ense number	29d. Dete si	ned (Month,	Day, Year)					
	11/1/45	M/ M	000	54756	SEPTE	MBER /	6 1999					
	30. Nama and address of person who	completed cause of death (Ite		. 0	, DELTE	TIDDI()	7					
 State	31. Dete filed (Month, Day, Year)	1 APP JV (112 Seton Dr	rive Lumbers	and 1	1D a	21502					
Registrar	OCD 1	7 1999 > penes	m B. So	and w								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

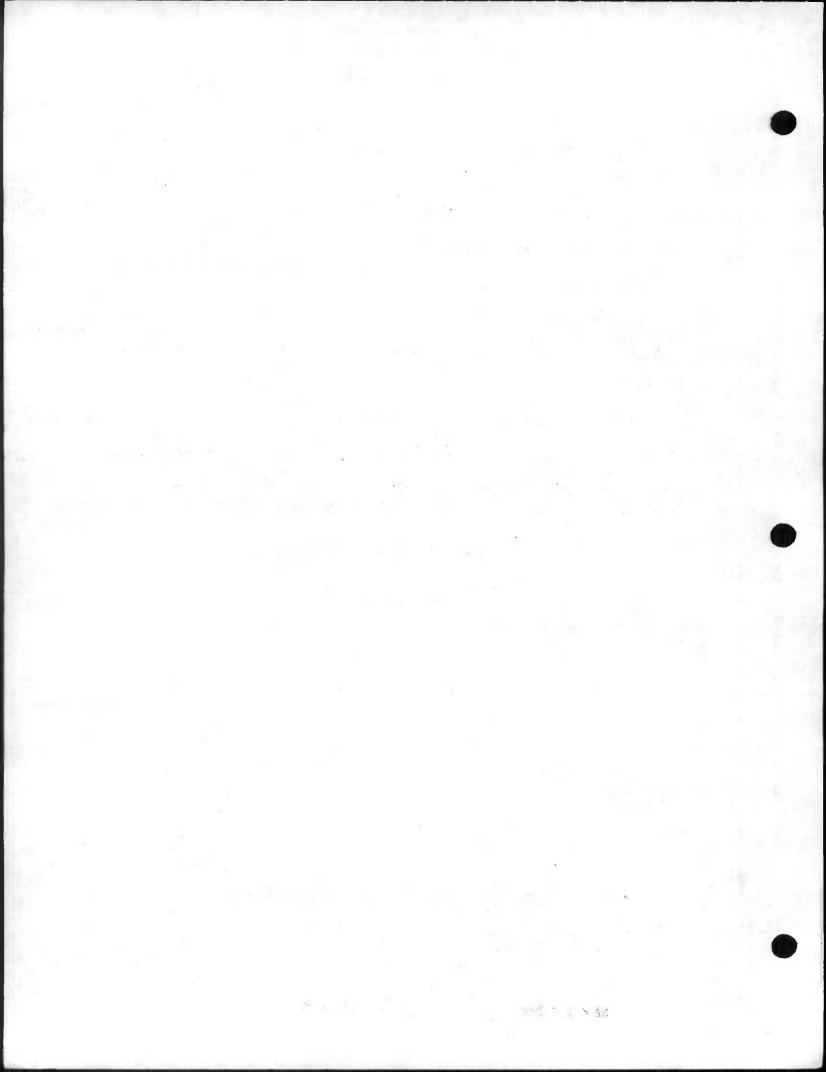
	Physic /Medi		RICHARD BURDET	TE WOLFE							Month SEPTEMB	ER 23,	Year 1999	12:55 PM
	Exami		4a. Facility Name (If not institution, give DENNETT ROAD MA		וכ עס	ME		4			ation of Death			
	Funeral Director		5. Social Security Number 6. Security Number 213–24–6376	7. Age		NE ast birthday) Yrs.	If Under 1 Months	Year Days	OAKLA If Under 2 Hours	24 Hrs. 8	B. Date of Birtl (Month, Day EC 28,	(, Year)		lece (State or Foreign try)
	h the Marylend r 28a-f show	ctor	Usual Residence of Decedent			, Town or Lo	cation						11	0d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28 let be no	ai Director	10e. Street end Number 1206 SUNNYSIDE	ROAD			10f. Zip 0	ode 1550)			10g. Citizen of V		try?
020	72 hours after death with the Maryland "natural", or items 23a or 28a-f show otest Evant must be notified at	by Funeral	11. Mantel Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:			Vas Decede f Yes, specif		spanic Orlg n, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		ce - America ck, White, o	etc.
21215-0020	d within giene. r than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondery (0-12)		+)	(Give life. L	lent's Usual kind of work OO NOT use	done a	luring most	of working	7	16b. Kind of B	Kind of Business/Industry ARMING	
Maryland	be filed tal Hygie d other event,	Be	17. Father's Neme (First, Middle, Last) CYRUS SYLVESTE	R WOLFE								Maiden Surnan	en Surname)	
ry je	Merke	70	CYRUS SYLVESTE			40b 84-111-	- Address /	C4	TOLA PHYLLI at and Number or Rural Route Nu			HAHN		
Ma	d 2 s		VIOLA WOLFE - WIF				SUNNY					MD 215		Code)
re,	of H of H r oth		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name	of			Date	20c. Location		wn, State
imo	0 4 4 7		1 Burial 2 Cremation 3 □I 4 Donation 5 □ Other (Specify,						*	ES 9/	26/99	OAKLAN	ID, MA	RYLAND
Baltimore,	permit. Pag Depertment important: I eny injury o		21. Signaturiyor Unangi Soyvice Licens	22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MARYLAN 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.										ID 21550
K 68760,	Physician /Medical Examiner a stending physician and dor race as the buriel-transit dor race as the buriel-transit	Medical Examiner	shock, or heart failure. List only of the shock of the sh	a. CONGES	TIVE Due to (or		FAILU uence of):		g, 30011 & 3 C	entriec of	ospirotory an	өэі,		Approximate Interval Between Onset and Death
.O. Box	y th	Physician/M	Part II. Other significant conditions co	a. ntributing to death bu	it not resul	ting in the ur	nderlying cau	ıse give	en in Part I.					the cause of death?
of Vital Records, P	requires been sign should be	Completed by P	COPD PARKINSONS DISEA	ASE							24e. Was a	an autopsy	24b. We	ore autopsy findings illable prior to moletion of cause leeth?
Ä	he he h	Com									1 🗆 Y	es 2 No	1	Yes 2□ No
/ita	certifice rector, p	Be	25. Wes case referred to medical examiner?					Ta.		of Death (Check only or	ne)		
	Jing Phys After this funeral di	ation: To	1 Yes 2 No 27. Manner of Death 120 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatier 28a. Date of Injury (Month, Day)		R/Outpatien 28b. Time of Injury		. Injury Work	4 LZL NUI	28		ence 6 Oth ow Injury occur		")
Division	in Street	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Inju building, etc.	. (Specify)						City or Tow	n, State)		Route Number,
	Mospital 24 hours e Funerel E letely filled	edicai	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination	ledge, death on and/or inv	occurred at estigation, in	the tim	e, date and Inion, death	place, an occurred	d due to the d l at the time, d	ause(s) end ma late and place,	anner as sta and due to	ated. the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier				29c. l	License	number		2	9d. Date signe	d (Month, L	Dey, Year)
			30. Name and eddress of person who co	muld cause of de	2 path (Item :	23e) (Type, I		261	54			SEPTE	MBER	24, 1999
			PAUL DANIEL MILL			WOLF		DR	IVE	OAK	LAND,	MD 2155	0	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire 6	1							

16.4

The state of the s

State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle, Last)	2. Date of Death 3. Time of Death										
Physiciar /Medica	nathy Ann Wiley	9 23 1999 11:30 a.m.										
Examine	4e Facility Name (If not institution, give street and number) 4b. C	City, Town, or Location of Death 4c. County of Death										
24		CHENTY Garrett Under 24 Hrs. R Date of Birth										
Funeral Director		Hours Min. Nov. 4, 1955 Sate of Birth (Month, Day, Year) Ohio										
Maryland a-f show	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 🗷 No										
ith with the Mar 23s or 28s-f at	10a. Street and Number 3538 Friendsville Road, PO Box 284 21541	10g. Citizen of What Country? USA										
1215-0020 within 72 hours after death with the Manyland one. than "natural", or items 23s or 28s-1 show the Manical Examiner must be notified at	3 Widowed 4 Divorced Yeer or Detes:	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white										
d 21215-0020 filed within 72 hours at hygiene. ther than "natural", or ont, the Medical Even	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 th 15. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) School Bus Opera	Garrett Co. Board of										
	17. Fether's Neme (First, Middle, Last)	. Mother's Name (First, Middle, Maiden Sumame)										
		Ruth Savage										
Maryland d 2 should be flie th and Mental Hy 7 is marked othe traumatic event	Company of the control of the contro	Number or Rural Route Number, City or Town, State, Zip Code)										
or Health of Hem 27	Stephen R. Wiley/husband 3538 Friendsvil 20a. Method of Disposition (Name of	le Rd., PO Box 284, McHenry, MD 21541										
Baitimore, I permit. Pages 1 and Department of Health Important: If New 27 any Injury or other 1 page.	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cemetery, crematory or other place) Oak Grove Cemetery,	Sept. 25, 99 McHenry, MD										
Bail Departiment any in	21. Signeture of Funeral Servica Licansee 22. Name and Address of Fecility Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536 Approximately shock, or heart halure. List only one cause on each line.											
	23a. Part1. Enter the sugara, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.	such as cardiac or respiretory errest, Interval Between										
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. Diseminated Cot	Course and Deeth 2 months										
	Oue to (or as a consequence of):	Several Venue										
68760, filter be executed physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	garrs.										
68760, licate be expension is the burial												
W = 0 = 0												
Geatte ed for a deatte	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Pert I. 23b. Did tobacco use contribute to the cause of death?										
		1 Yes 2 No 3 Probably 4 Unknown										
aw requires to be a second of the second of		24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to completion of cause of death?										
H ate h age of the		1 ☐ Yes 2 M No 1 ☐ Yes 2 ☐ No										
Vital vician: certifical rector, p	25. Wes case referred to medical exeminer?	6. Place of Death (Check only one)										
on of Vita sling Physician: h. After this certific funerel director,		4 Nursing Home 5 Pasidence 6 Other (Specify) 28d. Describe how injury occurred 2 No										
Division of the function of in by the funer function.	2 Accident Investigetion 3 Suicide 4 Homlcide Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)										
Hospi 24 hour Funer tely fill		date and place, and due to the cause(s) and manner as stated. on, death occurred at the time, date and place, and due to the cause(s)										
Within 2 To the comple	29b. Signature and title of certifier 29c. License nu	umber 29d. Dete signed (Month, Day, Year)										
	D136	001 9/23/99										
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Victor R. Fe Lipa 925 Bishop W	Jaish Rd Cumberland MD										
State	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	41502										



				n ivial ylai		rtificate of	Death		Reg. No.		1060
Phys	ician	Decedent's Nama (First, Middla	Last)					2. Data of Dea Month	Day	Yaar	3. Time of Death
	dical	William D. Welling	, Sr.					Septemb		999	08:21AM
Exan	niner	4a Facility Nama (If not institution	giva street and nu	mber)			4b. City, Town, or Lo	ocation of Death			
		Sacred Heart Hospi					Cumberland		Allega		
Funer Directo		5. Social Security Number 212-38-5345	6. Sex 1 X M 2 □ F	7. Age (In yrs. 60)	last birthday) Yrs.	If Under 1 Year Months Days		8. Data of Birth (Month, Day 13-Nov-	h v, Year) 38	9. Birthi Cou Maryl	placa (Stata or Foreign htry) and
anyland show	Ę.	Usual Rasidence of Decedant 10a. Stete 10b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits 1 1 Yes 2 □ No
No M	Director	Maryland Alleg	jany	Fros	lburg						
ith to	ā	10a. Street and Number 1930 l	Upper Cor	isol Road		10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
ath y	<u>a</u>					21532-			U.S.A.		
A LE 13-002.0 I within 72 hours after death with the Manyland glene. Per than 'natural', or forms 23a or 28a-f show the Medical Exeminar must be notified as	by Funeral	11. Merital Stetus 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced	Armed F	2 No		Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 1 No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, atc.)	Specify	k, White,	can Indien, atc.
72 hours	8	15. Decedent	Education		16a. Deced	dent's Usual Occu	pation		16b. Kind of Bu	sinass/In	dustry
9 .	Completed	(Specify only highas Elementary/Secondary (0-12)	grada completed) College ((Give	kind of work done DO NOT use retire	during most of work ad)	ing			
filed withir Hygiena. ther than	E O	11	0	1401 347	Nurses	s Assistant			Hosital		
be filed tel Hygie d other	Be	17. Fathar's Nama (First, Middla, L	ast)				18. Mother's Name	a (First, Middle,	Maiden Sumam	a)	
	2	Unknown					Edith Davis	5			
2 should and Men is marke		19a. Informant's Name/Ralationsh	p (Type, Print)		19b. Mailir	ng Address (Stree	t and Number or Run	al Routa Numbe	r, City or Town,	State, Zij	Code)
		Mary Wellings	Wife		19301 U	pper Conso	Road Fros	tburg	Marylan	d	21532-
of Heel		20a. Mathod of Disposition	. C.D		Place of Dispo	sition (Name of natory or other pla	ace)	Data	20c. Location -	City or T	own, State
Peges nent of nt: # its		1 Burial 2 □ Cremetion 4 □ Donation 5 □ Other (Sp		State		morial Park		6-Sep-99 Frostburg, Maryland			
Destruction of permit. Peges 1 et Department of Hee Important: If Item: any Injury or othe	DUCE	21. Signeture of Funaral Sarvice L	Censor	est		2. Nama and Addr Urst Funero	ess of Fecility I Home, 57 F	rost Ave.,	Frostburg.	MD :	21532
Physicia	,	23a. Part1. Entar tha disaasa, or shock, or haart failura. List o	nly one cause on	aach line.					rest,	6	Approximeta Interval Batween Onset and Death
/Medica Examine	al er	Immediata Causa (Final disaasa or condition resulting in death)	a. 50	1 D1) 15 1	or as a conseq	PAD) A (DEAN	9-		1	
P is	Examiner		b. Co	RUNG	Ry A	ARTERY	DISEA	SA		- 1	Two year
the deeth certificate be executed by the attending physician and sched for use as the bunal-transit	хал	Sequentially list conditions, if any, leading to immediate		Due to (or as a conseq	luence of):	7	, ,			
ficate be ex physician as the burial	caiE	Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disease or Injury	c. Cox	CONARY	AR	TERYO ST	LEROS	19			
s the	얼	that initiated events rasulting in death) Last		Due to (or as a conseq	uence of):				i	
antification of the season			d							i	
eeth certifica attending pl	lan										
at the de d by the detached	Physician/M	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying cause g	iven in Part t.	23b. Did 1	obacco use co	ntributa t	o the cause of death?
s that	by	DIABET.	yn c	HRON	TIE /	ENM	CATLUPE	10'	Yes 2□No	3 Pro	bably 4 Unknown
sw request should	Completed	DIARET.	El MB	lun	5 Hy	PARLIN) Som	24a. Was perfo	an autopsy rmed?	an CC	fere autopsy findings vailabla prior to omplation of cause death?
	Ö							101	as 2 No	1	□ Yas 2□ No
yalcfan: The is certificate director, pag	Be	25. Was case rafarred to medical axaminar?					26. Place of Deat	h (Check only o	ne)		
Physician: T this certificat ral director, pr	2	1 ☐ Yas 2 No	Hospital:	Inpatient 2	ER/Outpatien	N 3LI DOA		ma 5 🗆 Resid	lence 6 □Oth	ar (Speci	ty)
After fune	sation:	27. Mannar of Death Natural 5 ☐ Panding 2 ☐ Accident Invastig	ition	of Injury th, Day Year)	28b. Time of Injury	We	iry at ork?] Yes 2 □ No	28d. Describe h	now injury occur	red	
tal or Att	Certifi	27. Mannar of Death Sala Natural 5 Panding Invastigation 28a. Data of Injury 28b. Time of 28c. thiury at work? 28c. thiur						28f. Location (S City or Tox		er or Rur	al Route Number,
To the Hospital or Attend within 24 hours after death To the Funeral Director:. completely filled in by the	edical		caminer: On the b				ime, date and place, opinion, death occurr				
To trop	Σ	29b. Signeture end title of certifiar				0	se number		29d. Data signe		
	0	offer of	6			\$ 26	907	S	EPTEMBE	R 24	1999
	ומ	30. Nama and addrass of person w	ho complated caus	se of death (Ite	m 23a) (Type,					7	1 1 1 1
/	tate	Harjit Sidhu, M		Bishop Egistrar's Sign		Drive, C	umberland	, Maryla	and 2150)2	
Regis		SEP 271	399 1	Anna	D.	doore	2				

Detailed to the second of the

	Director	
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or ferms 23s or 28s-f show any lijury or other traumatic event, the Medical Examinar must be notified at pages.	To Be Completed by Funeral Director
	Physician /Medical Examiner	-
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit	Medical Certification: To Be Completed by Physician/Medical Examiner

					State of IVI		Certifica			ı	Reg. No.	94	0.2.0	
	Physici	an	1. Decedent's Name				- 5			2. Date of Dea Month	ith Day	Yaar	3. Time of Death	
	/Medi		Jack	Gene	Walker					SEPTEM			08:20 p.	
	Examir		4a Facility Name (If	not institution, giv	re street end number)				4b. City, Town, or L		4c. County			
				ary's Hos	spital				Leonardto			Mary's		
	Funeral Director		5. Social Security No. 399–34–2. Usual Residence of	511	TVM 2□ E	e (In yrs. last birt	rs. If Unde Months	Days		8. Date of Birth (Month, De) NOV. 6,	1937	9. Birthpla Countr Illin	ca (State or Foreign y) OIS	
	and w		10a. State	10b. County		10c. City, Town	or Location					100	d. Inside City Limits	
	Meny Ff ehr	Director	MD	Harford	Ē	Aberde	een						₩XYes 2□No	
	or 28s		10e. Street and Num	nber			10f. Zi	p Code			10g. Citizen of \	What Countr	y?	
	th will		622 S	. Rogers	Street		21	001			U.S.	A.		
20	n 72 hours efter death with the Meryland "netural", or items 23s or 28s-f show epical Expenses must be notified at	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed		12. Wes Decedent Armed Forces? 1 Tyes 2 1 If Yes, Give		13. Was Dece If Yes, spe		Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yas or No- Pican, etc.)	Bla	a - America ck, Whita, a Whit	tc.	
Maryland 21215-0020	2 hou	pe		15. Decedent's Ed	ducation		Decedent's Usu	al Occu	pation		16b. Kind of B	usiness/Indu	istry	
215	C ' 61	Completed	(Speci	ify only highast gre odary (0-12)	ede completed) College (1-4or 5	5+)	(Give kind of wo life. DO NOT u	ork done ise retire	during most of work ed)	king				
2	be filed within tel Hygiene. d other than avent, the Me	Som	12	104.7 (0 .27	0		litary				U.S. A	army		
pu	be filed tel Hygi d other	Be	17. Father's Name ()				18. Mother's Nam			18)		
yla	2 should be and Mentel is marked or reumatic eve	ပ္	John E.						Ruby	Linhar				
Jar	VI 00 -		19a. Informant's Na				-		t and Number or Ru					
					er (Spouse		Disposition (Ne		rs Street	, Aberde	20c. Location			
Baltimore,	Pages ant of rt: If it y or c		4 Donation	Cremation 3 5 Other (Specif		cem eter	d Memor	ial	Gardens					
Ball	permit. Pa Departmen Important: any Injury pace.		21. Signature of Fur	Service Licer	IS C				ess of Facility Cargo Fund , Maryland	eral Hom	e. P.A.			
N - N	Physician /Medical Examiner	Jer.	23a. Part1. Enter th shock, or hear immediate Cause (I disease or condition resulting in death)	Finai	plications that causar one cause on each li a. ATL		ente	i	Ceulu				Approximate Interval Between Onsat and Death	
Box 68760,	certificate be executed nding physician end use as the buriel-trensit	an/Medical Examiner	edical	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		b	Due to (or as a c							
P.O. Bo	thet the deeth certified by the ettending deteched for use a	Physician/M	Part II. Other signifi	cant conditions o	contributing to death b	ut not rasulting in	the underlying	cause g	iven in Part I.		obacco use co		the causs of death?	
of Vital Records,	requires been sign should be	Completed by									an autopsy med?	ava	re autopsy findings ilable prior to apletion of cause eath?	
R	0 - 0	mo								10	res 28 No	10	Yes 2 No	
ta	Iclan: The certificate rector, pag	Be C	25. Was casa rafarr	red to medical					26. Place of Dea	ath (Check only o	one)		//	
>	\$ 0 TO	To B	examiner?	No	Hospital:	ent 2 ER/Ou	tpatient 30 D	OA O	ther	lome 5 Resid		nar (Specify,)	
0	g Ph		27. Mariner of Death	5 Pending	28a. Date of Inju		ime of njury	28c. tnj	ury at	28d. Describe	now injury occu	rred		
Division	To the Hospital or Attending Phy within 24 hours effor cleath. To the Funeral Director: After thi completely filled in by the funeral	Certification:	Naturat Accident Suicide Homicide	investigatio	n 28e. Placa of th	jury - At home, fa c. (Specify)	М	1[]Yas 2□No		cation (Street and Number or Rurel Route Number, ty or Town, State)			
_	To the Hospital of within 24 hours of To the Funeral D completely filled in	edical C	29a, Certifier (Check only one)	Certifying Pt	nystclan: To the best miner: On the basis o and manner st	f examination and	, death occurred Vor investigation	d at the t	ime, date and ptace opinion, death occu	, and due to the rred at the time,	cause(s) and m date and placa,	anner as sta and due to	ated. the cause(s)	
	within To the comp	×	29b. Signature and	title of certifier	,		29	c. Licar	isa number		29d. Date signe	ed (Month, E	Day, Year)	
		1	1	NB	m to	mn		01	7285		9-2	2-	99.	
	C	5	30. Name and addre		completed cause of c		Type, Print)	Pai	ut Look	Cout R	Papel 1	enond	99. 1, md. 2065	
	Sta Registi		31. Date filed (Mont		32. Registi	rer's Signature	B. A	100	ile		1	e i o je jest	1.01.000	

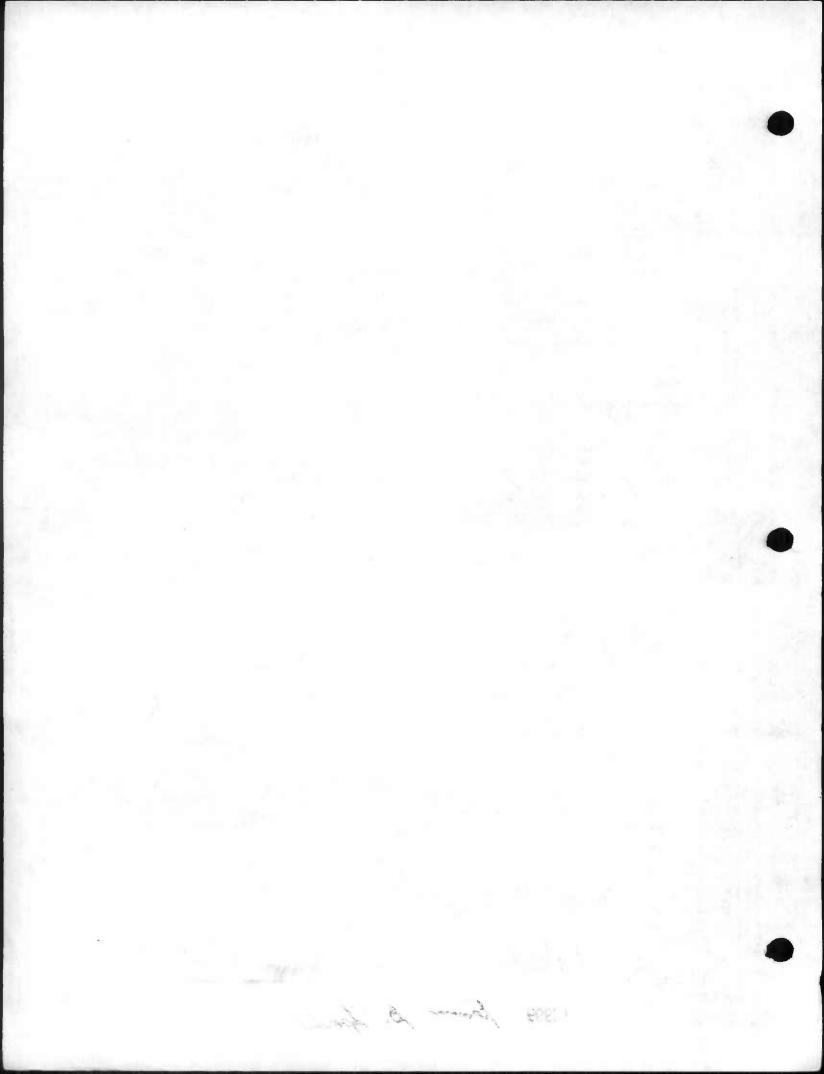
Jack Gene Walker

SEP 2 2 1999

73.55

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State	OI Waiyiane		ficate of	neaith and iv Death		Reg. No.	J	1341		
Physician	Decedent's Name (First, Middle, Last)					2. Dete of De Month	ath Day	Year	3. Time of Death		
/Medical	Jewel P.		Zawas			SEPTEME	ER 18 19	999	2:03 PM		
Examiner	4a Facility Name (If not institution, give street and n MEMORIAL HOSPITAL	number)			4b. City, Town, or Lo		4c. County				
Funeral Director	5. Social Security Number 6. Sex 1 M 2 K F	7. Age (In yrs. Ia 86	A	f Under 1 Year Months Days		8 Date of Bir		9 Rirtho	lece (State or Foreign		
and w	Usual Residence of Decedent 10a. State 10b. County	10c. City,	, Town or Local	ion				1	0d. Inside City Limits		
Mary	MD Allegany		Cuml	perlan	d				1 Yes 2 No		
with the	10e. Street and Number 1428 Magnolia Court			10f. Zip Code	21502		10g. Citizen of Whet Country?				
Aaryland 21215-0020 2 should be filed within 72 hours after death with the Maryland la marked other than "natural", or herm 23s or 28s-f show raumatic event, the Medical Eventher, must be notified at To Be Completed by Funeral Director	11. Merital Status 1 Never Merried 2 Married 1 Never Merried 2 Married 1 Yes 1 Yes 1 Yes 1 Yes	cedent Ever in U,S Forces?, 2 DANo Give		s Decedent of Hes, specify Cub	lispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Bleck	e - Americ k, White,	etc.		
Baltimore, Maryland 21215-0020 semit. Pages 1 end 2 should be filed within 72 hours at reportant of Health and Mental Hyglene. mportant: If item 27 is marked other than "natural", or may higher or other traumatic event, tra Medical Farmings. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	16a. Deceden (Give kin life. DO Homema		pation during most of works d)		16b. Kind of Bu	isiness/Inc			
and 2121 the filed within nits Hygiene. ed other than "event, ma Me	17. Father's Name (First, Middle, Last)		пошеша	rker	18. Mother's Name						
aryland 2 should be filed v and Mental Hyglic n marked other t umaric event, to	Roy G. Henry				Cora E		nholtz)	,			
end 2 should selth and Men n 27 la marke or traumate	19e. Informent's Name/Reletionship (Type, Print) Janice R. Harper		19b. Meiling / 1428	Address (Street Magnol	end Number or Rura ia Court	; Cumb	er, City or Town, erland	State, Zip MD			
Imore, M Pages 1 end 2 ient of Heelih int; if item 27 ii	20a. Method of Disposition 1 2 Burial 2 Cremetion 3 Removal from 4 Donation 5 Other (Specify)	n State	ace of Dispositi	ory or other pla	Park	Dete	20c. Location -				
Baltime permit. Pag Department Important: It any Injury o	21. Signeture of Funeral Service Consee	An	> 25 N	arper	Isf Funer and, Mar	al Hor			a, mp		
Physician	23a. Part1. Enter the disease, or complications thet shock, or heart feilure. List only one cause on	t caused the death.							Approximate Intervel Between Onset end Death		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of):										
Box 68760, stending physician and for usa as the bunki-transit clar/Medical Examiner	Cause (Disease or Injury that initiated events cesulting in death) Last Due to (or as a consequence of):										
P.O. BOX not the death cert by the attending elsched for usa a Physician/M	Pert II. Other significant conditions contributing to	death but not result	lting in the unde	riying cause giv	ren in Pert I.	23b. Did	tobacco (usa con	ntributa to	the cause of death'		
P.O. in that the ned by the detache	CHF					10	Yes 200 No	3 ☐ Prot	bebly 4 Unknow		
4-34-1939 al Records, P.O. Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for usa a Completed by Physician/M.							an autopsy med?	ave	ere autopsy findings eilable prior to mpletion of cause deeth?		
214-34- Vital Rec vital Rec vitalen: The law contificate has b director, page 2 s						10	Yes 20 No	10	Yes 2□ No		
Vita Vita Vita Sertific ector,	25. Wes case referred to medical axaminer?	7		011	26. Place of Deetl	(Check only o	one)				
ASKI On of N Ing Physi h. After this of funeral direction: To	27. Mariner of Death 28a, Det	e of Injury	R/Outpatient 28b. Time of		4 LI Nursing Ho		dence 8 Other	-	y)		
Division of Attendant date deat deat deat deat deat deat dea	28a. Dáte of Injury 28b. Time of Injury 4 Work? 28b. Dáte of Injury 28b. Time of Injury 4 Work? 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28d. Dáte of Injury 4 Work? 28d. Dáte of Injury 4 Work? 28d. Dáte of Injury 5 Work? 28d. Dáte of Injury 4 Work? 28d. Dáte of Injury 4 Work? 28d. Dáte of Injury 5 Work?								I Route Number,		
To the Hospital of within 24 hours a To the Funeral D completely filled i	29e. Certifier (Check only one) 12 Certifying Physician: To the Check only one)	ne best of my knowl basis of examination	ledge, death oc on and/or inves	curred et the tir tigation, in my o	ne, date end place, pinion, deeth occurr	and due to the ed et the time,	cause(s) end me date end place, a	nner es si and due to	tated. the cause(s)		
Within To the compi	29b. Signeture and titlero contrier			29c. Licens	e number		29d. Dete signed	d (Month,	Day, Year)		
	Theshur			Do	033280		Sept 22	,199	3 9		
42	30. Nama and address of person who completed cau SUNIL GUPTA M.D., 625 K				MD 21502	SUITE 1	.01				
State Registrar	31. Dete filed (Month, Day, Year) 32. SEP 2 2 1999	Registrar's Signatu		do							



				State of Maryland / Department of Health		ntal Hyg	giene q	9 3	1528
MEN	NDED	ITEMS #	¥1 8	#5 PER MD & FH G776 10/08/99 AH Certificate of Death	h	F	Reg. No.		1020
	п	Dhysisi	lan	1. Decadent's Name (First, Middle, Last) JOSEPH ANTHONY ANNELLO	2.	. Data of Das Month	ath Day	Yaar	3. Tima of Death
		Physici /Medi		HNNELLI JOSPAH		10.	2/ -	99	10:10A
	1	Examir			Town, or Local	tion of Death	4c. County		
	_			5. Social Security Number + 6. Sex 7. Ana /in vrs. lest hirthdey) If Under 1 Year If Under	ar 24 Hrs. 8	wa		N/A	
		Funeral Director		318-18-5875 1 1 M 2 F 7 4 Yrs. Montha Days Hours	Min. 8.	(Month, Day	7, Year) 7, 1924	9. Birthpla Counti Mar	aca (Stata or Foreign y) yland
				Usuel Rasidance of Dacedant		pept.	1,1924	Mai	yrand
		2 should be filed within 72 hours efter death with the Maryland end Mentel hygiene. Is merked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner man be notified at		10a. Stata 10b. County 10c. Cay, Town or Location	1			10	d. Insida City Limits
		Mar Bried	ş	md BALTO. Ma	1				1 das 2 No
		n 72 hours efter death with the Marylar "natural", or flems 23a or 28a-f show polical Evantiner must be notified at	Funeral Director	10e. Street and Number 10f. Zip Coda			10g. Citizan of V	Vhst Counti	ry?
		23a (23a)	ai	501 W HRANKLIN ST 2120	1		U	SA	
		and	In le	11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic O If Yas, specify Cuban, Maxica	Orlgin? (Specifian, Puarto Ric	y Yas or No-	14. Rac	a - Amarica ck, Whita, a	
	20	or it		1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 ☐ No WWII 1 ☐ Yas 2 ☐ No Specify		,	Specify	41	
	Baltimore, Maryland 21215-0020	ural',	d by	3 Wildowed 4 Divorced Yaar or Dates:	,			W	hite
	15	should be filed within 72 ho nd Mentel Hygiene. merked other than "natur imetic event, ine Medical	Completed	15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during mo lifa. DO NOT use ratired)	ost of working		16b. Kind of Bu	isiness/indu	ustry
	12	within than	Ę	Elamantary/Secondary (0-12) Collega (1-40r5+) Merchant Seaman			Merch	ant M	arines
	P	Hygi ther ant,		0 ledis		First, Middla,	Maidan Sumam		arrics
	lan	entel ked o	To Be	Samuel A. Annello		a LoGr			
	ary	and M meri	-	19e. Intormant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Numb	ber or Rural F	Routa Numbe	r, City or Town,	Stata, Zip (Code)
	Σ	s 1 and 2 should f Heelth end Mer item 27 is marke other traumatic		Frances Maivelett/Sister 5707 Hamilton Ave		ltimor	-	21237	
	re,	of Heeith of Heeith fitem 27 I		20a. Mathod of Disposition 20b. Place of Disposition (Nema of cematery, cremetory or other place)		Data	20c. Location -	City or Tow	vn, Stata
	m	permit. Pages Department of I Important: If its eny Injury or o		1⊠ Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Garrison Forest V.A.Co	em. 10	/7/99	Owings	Mil1	s, MD
	alti	permit. Departm Imports eny inju		21. Signatura of Funarai Sarvica Licansaa 22. Nama and Addrass of Facil	ility				
	m	Depa Impo		Duda-Ruck Fun					
				7922 Wise Av 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as sho or heart tailure. List only one cause on each line.	re. Du	aspiratory ar	Maryla		21222 Approximata
		Physician	9	show or haart tailura. List only one cause on each line.					Intarvsi Between Onsat and Death
	ш	/Medical		Immediate Cause (Final disaasa or condition	C			1	
		Examiner		rasulting in death) a.					
	1	D ≈	ner	PANCREATIC CA	ANC	ER			
		icete be executed physician end s the buriel-transit	Examine						
	90	sian e	E I	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury	VE L	LING	DISE	75	
i	8760,	hysic the b	dicai	that initiated avents rasulting in death) Last Dua to (or as a consequence of):					
	9	nding phuse es t	Me					-	
)	Вох	leath certific attending p	lan	U.					
	o	The lew requires that the death ate has been signed by the atter page 2 should be detached for r	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.	23b. Did t	obacco use col	ntribute to	the cause of death?
	P.0	het thed by detac		DIABETES MELLITUS		100	res 2□ No	3 Probe	ably 4 Unknown
	ds,	signe d be	i by			NAME OF THE PARTY OF	et en archa	045 14/0	en autonou fin din en
	Ö	redu	Completed			24a. Was perfor	med?	avai	ra autopsy findings llabla prior to aplation of causa
	Sec	has t	id I					of de	eath?
	a F					1 🗆 Y	as 2 No	1 🗆	Yas 20 No
	N S	Physicien: The lew this certificate has ral director, page 2	Be	axaminar/	ce of Death (C				
	o	this aldi	To	1 Inpatiant 2 ER/Outpetlent 3 DOA			ence 6 Oth)
	L C	tending Physicien: leath. tor: After this certific the funeral director,	lon	1 Natural 5 Pending (Month, Day Year) Injury Work?	21No 200	d. Dascribe n	ow injury occur	60	
	Sic	death death tor:	Ical	3 Suicida 6 Could not be	,	Location /9	treet and Numb	er or Bural	Pouts Number
	Division of Vital Records,	or A efter Direct	Certification:	4 Homicida datarmined building, atc. (Spacify)	200	City or Tow		er or Hurar	Hodia Nulliper,
	_	ours ours filled		29a. Certifiar 12 Certifying Physician: To the best ot my knowledga, daath occurred at tha tima, data at	and place, and	due to the	euce/c) and me	nner ec eta	ated
		To the Hospital or Attending F within 24 hours effer death. To the Funerel Director: Affer completely filled in by the funer	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, da and manner stated.	eath occurred	at tha tima,	data and place,	and dua to	tha causa(s)
		Vithin To the	Me	29b. Signature and title of certifier 29c. Licensa number	r	1	29d. Data signe	d (Month, D	ay, Year)
d				D414	30		10 -	6-	99
U				30. Name end addrass of person who complated causa of deeth (Item 23e) (Type, Print)				0	//
				30. Name end addrass of person who complated causa of deeth (Item 23e) (Type, Print) 530940LDCOURT RPAD RANDA 31. Data tiled (Month, Day, Year) 32. Registrate Signatura D	ALLST	OWN	no	211	133
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Bransdon Anthony Bailey 22,1999 September 2050 Hrs 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month Day, Year Aug 16, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 1**∏**M 2□ F Deys Hours Min 75 Yrs 214 37 2005 Usuel Residence of Decedent India 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD Montgomery Gaithersburg 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 18911 Mills Choice #6 20886 India 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No 1 Yes 2 No Specify: Specify: India 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 2 years Print Factory Foreman Painting 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) William Bailev Gertrude Bailey 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8313 Flower Ave - Takoma Park, Maryland Margaret Bailey 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State Gate of Heaven 9/27/99 Silver Spring, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Sam Butler & Sons Inc. 716 Kennedy St, N.W. Washington, D.C. 20011 23e. Part1. Enter the disease, or complications that flaused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one clause on leach line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in death) Acute Ventricular Arrythmia minutes Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 3€ Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings 24e. Wes an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2☐ ER/Outpetient 3☐ DOA 27. Manner of Death 28e. Date of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

the death certificate be execu Box 68760, P.O. Division of Vital Records, or Attending Physician: **Physician**

/Medical

Examiner

Directo

Funeral

79

Completed

Funeral

Director

7 is marked other than "natural", or fems 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural, or Hem any injury or other traumatic event, the Mentel Exercises

Physician /Medical

Examiner

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24 hours after deat Funeral Director:

To the I within 2 To the P

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Examiner

Physician/Medical

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Certification:

Medical

29a. Certifier

(Check only one)

altimore, Maryland 21215-0020

with the Maryland

death

State Registrar

Kleir 31. Dete filed (Month, Day, Year)

29b. Signeture end title of certifier

32. Registrar's Signeture

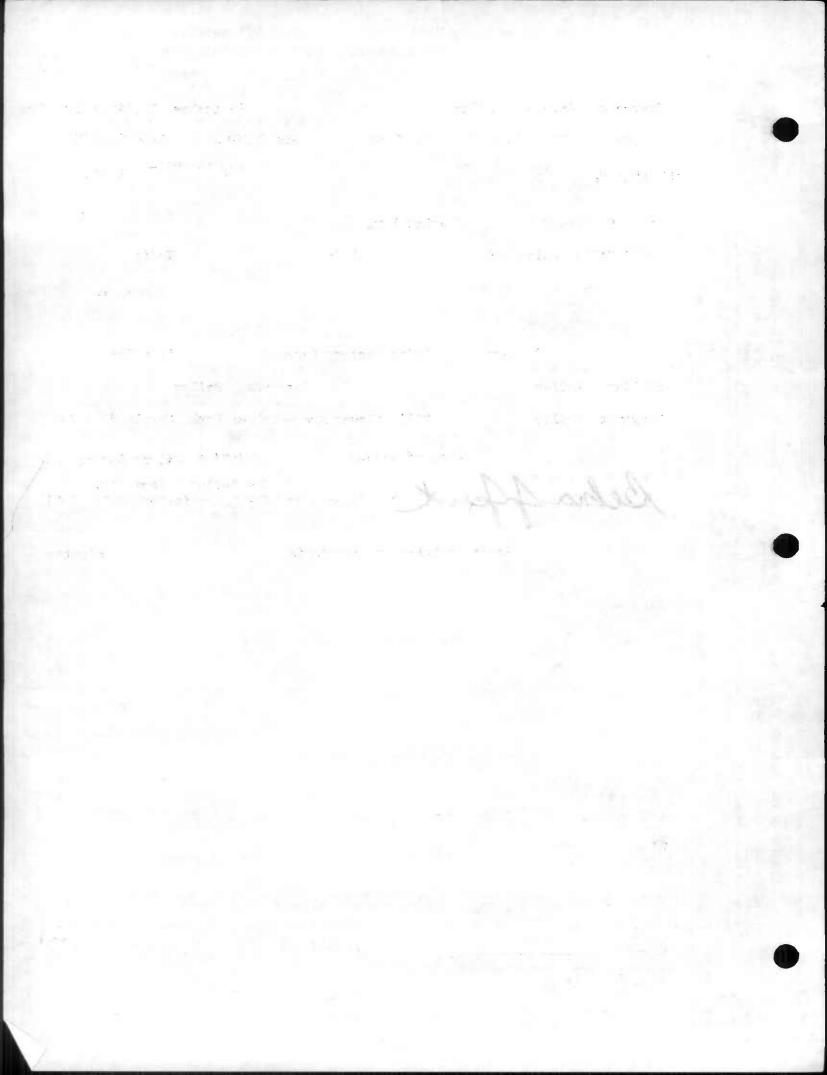
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

🖎 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) end manner stated.

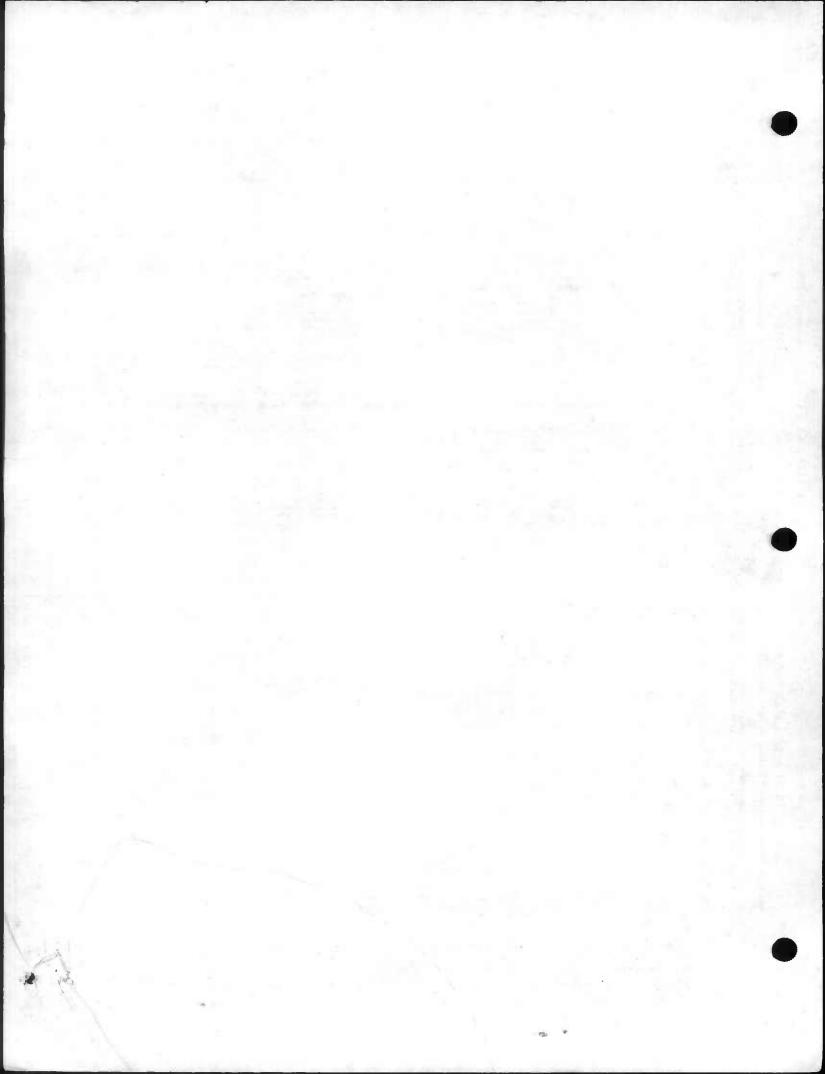
29c. License number 038847 29d. Date signed (Month, Day, Year)

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Funeral Director		210-17-7072	7. Age (In y	79 Yr	Month		Under 24 Hrs Hours Min	8. Date of B (Month, D	irth Day, Year)		ce (State or Foreign
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and 2 27 la		HOWAR TONES /RASALE	WEEMS (DAUGHT		41 Fo.	REST	PARK	AVE. L	BALTIMO	RE, M	D.
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Page Ht: H		12 Buriel 2 □ Cremetion 3 □ R 4 □ Donation 5 □ Other (Specify)	emovel from State				mercoll	119-99	BAITI	UADE	MARYLAND
and south	1	21. Signature of Funerin Service Ligense	0	MIGHT	22. Name	end Address	of Facility	20-1-11	TO EL	DEPA	AL HOME
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Physician		speck, or heart tailure. List only on	e cause on eech line.								ntervel Between Onset end Deeth
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Attending Physician: r death. sctor: After this certific by the funeral director.	ati	2 Accident Investigation			М	1 🗆 Ye	s 2 No				
or Atte after de Directe d in by t	Certification:	3 Sulcide 6 Could not be determined	28e. Plece of Injury - A building, etc. (Spe		n, street, fecto	ory, office		28f. Location City or T	(Street end Numb own, State)	er or Rural f	Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely lilled in by the funeral director.	edicai C	29e. Certifier (Check only one) Certifying Phys	clan: To the best of my ker: On the basis of exam and menner steted.	knowledge, d inetion end/c	leath occurre or investigation	ed at the time, on, in my opini	date end plac ion, death occ	e, end due to th urred at the time	e cause(s) end ma e, date and piece,	nner as stat and due to th	ed. re cause(s)
vithin o th	Σ	29b. Signeture and title of certifier			2	9c. License n	umber		29d. Date signe	d (Month, De	ıy, Year)
FXFO		Narin Babitt, M.D. RES 000 OCTOBER								-R 6	1999
	-	30. Name and address of person who con	nnieted cause of death (I	tem 23a) (Ty	(pe, Print)						21215
		31. Dete filed (Month, Day, Year)	32. Registrer's Sig				. MVE	· , DAL	IIMOR	-, 1-11	, 01013
Stat Registra	٠	00T 0 8 1999	oz. registrer s Sk	grieture .	632	1100					



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** NELLIE E. BROWN October /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Huspital 3t Day timore Baltimore City N/A Sinai If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 10-28-32 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 21 F Months 212-32-1671 66 Yrs. MD. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD. BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 124 MELOR AVE. 21228 USA Funeral 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11. Marital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SWITCHBOARD OPERATOR RADIO STATION 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 10 JAMES FLINT NELLIE HALL 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM BROWN (HUSBAND) 124 MELOR AVE. CATONSVILLE, MD. 21228 20b. Place of Disposition (Neme of cematary, cremetory or other place) 20a. Method of Disposition Dete 20c Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State BALTIMORE NATIONAL 10-13-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) nature of Funerel Sarvice Licensee 22. Nama end Addrass of Fecility PHILLIPS FUNERAL HOME, P.A. -8+ ector 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. **Physician** 14 days /Medical Immediate Cause (Finel brain INJUV disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? ves 2□No 1 ☐ Yes 2 ☐ No certificata director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No Certification: To Impatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 D Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es stated. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end manner stated. Medical 29a. Certifier completely (Check only one)

Hospital or Attanding Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Division of Vital 24 hours after death. Funeral Director: A Within 2 To the

Nollie Brawn

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trest.

Baltimore,

State Registrar

Desencia T 31. Date filed (Month, Day, Year) 1999 OCT

2401 homas 32. Registrar's Signatura

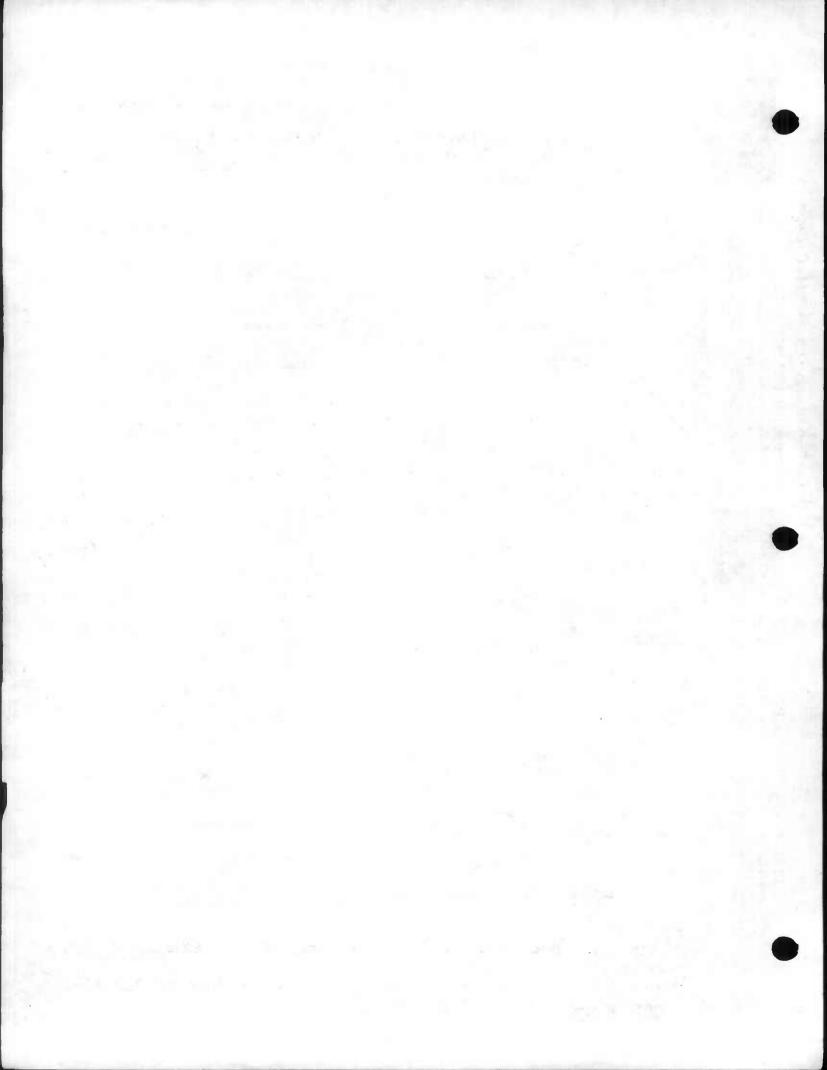
10mas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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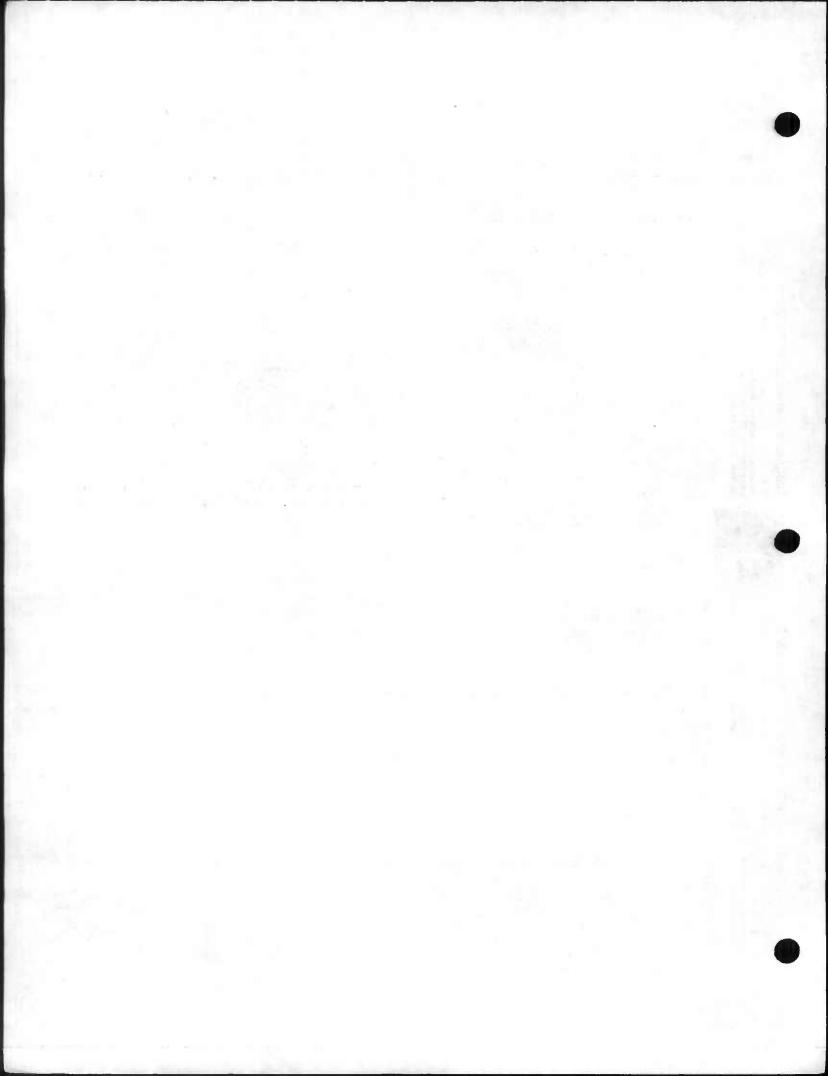
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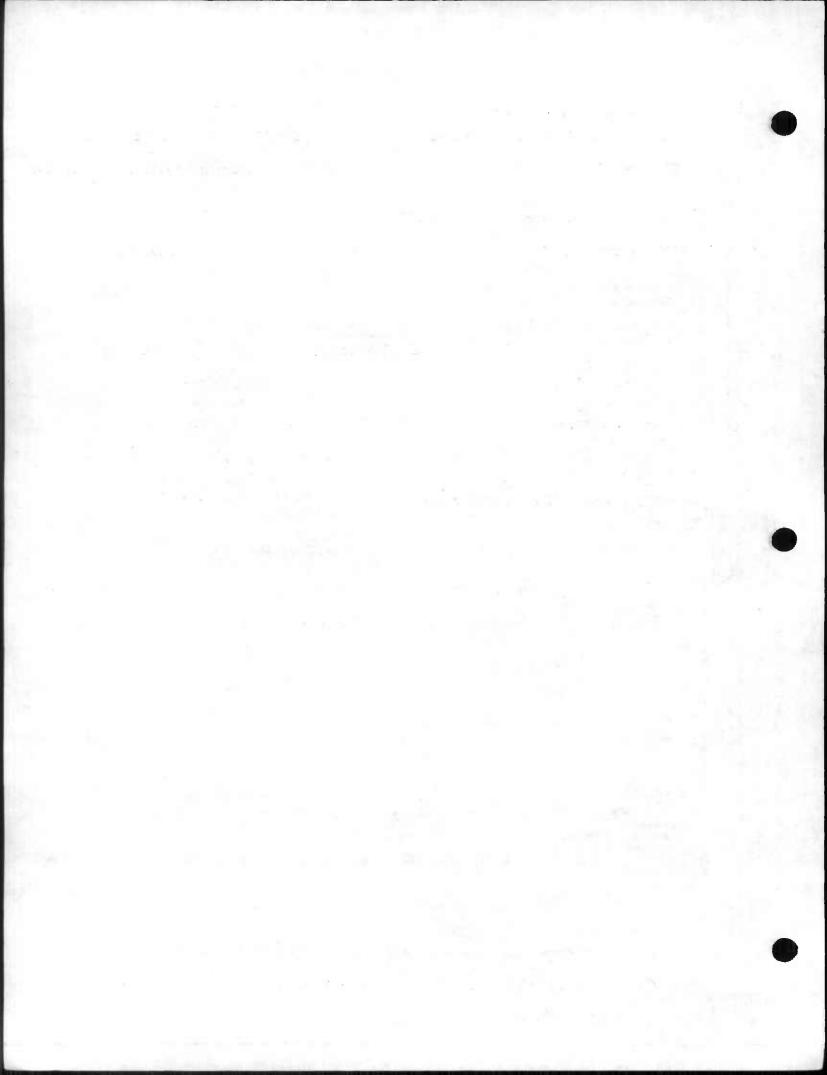
State of Maryland / Department of Health and Mental Hygiene 99 3 | 532

			Ce	rtificate of	Death		Reg. No.			
Physician	Decedent's Nama (First, Middle, Last)					2. Dafe of E Month		Year	3. Tima of Death	
/Medical		Walter L.	Br	ewer		Octob		199	2:50 PM	
Examiner	4a Facility Name (If not institution, giv	ra street and number)			4b. City, Tow	n, or Location of Dea	th 4c. County	of Death		
	800 Lynn Lee Drive Aberdeen							Harford		
Funeral Director	5. Social Security Number 6. Sex 1. Aga (In yrs. last b						of Birth h, Day, Year) 9. Birthplace (Steta or Foreign Country) Ohio			
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Merylar a-f show drad at	10e. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limit 10d. Inside									
h with the Me 3a or 28a-f a at be notified	10e. Street and Number 3204 River Driv		10f. Zip Code	19	10g. Citizen of What Country? United States					
5-0020 72 hours effer death with the Menyland returns, or items 23e or 28e-1 show dies Examiner must be notified at eted by Funeral Director	11. Marital Status 1 Nevar Married 2CMarried 3 Widowed 4 Divorced	1 Nevar Married 2 Married 1 3 Swa 2 No WW		Was Decedent of ff Yas, specify Cul	ban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	ify Yes or No- lican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. Specify: White			
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	P∑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			matory or other plants		8/1999	Baltir	nore,	Maryland	
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/Medical Examiner	fmmediata Causa (Final diseasa or condition rasulting in death)	8	ma C	euncer of):					7 mo.	
death certificate be executed e attending physician and ed for use as the burlat-transit sician/Medical Examiner	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): c. Dua to (or as a consequence of): d.									
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2 2 8 8							av	ere eutopsy findings allable prior to impletion of cause death?		
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Iclan: The Iclan: The Iclan: The Iclan: The Iclan: The Iclan	25. Was casa rafarred to medicaf				26. Place o	of Death (Check only	(one)		Daughter	
	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA O	ther		/	ar (Snacil	_	
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bal or Attanding P is after deeth. al Director: After is of in by the funeration: Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28a. Place of Injury - Al building, atc. (Spe	home, ferm, st	erm, street, fectory, office 281. Location (St City or Town				Street and Number or Rural Routa Number, vn, State)		
Hospi 4 hou Funer tely fill	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, date end place, end due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data end place, end due to the cause(s) and manner stated.									
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F S F Ö	m. o.			D	0	10/5/99				
	30. Name and addrass of person who MYO MIN (M. 2	completed causa of death (ft	em 23a) (Type,	Print)	rz06	, BALTI	MORE, 1	nD 2	21237	
State Registrar	31. Data filed (Month, Day, Year)	32. Registrar's Sig		Spour	b					



State of Maryland / Department of Health and Mental Hygiene

				Centitio	ate of	Death	- 3	Reg. No.	010	00	
oion	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 26, 1999 6:40pt								ima of Death		
cian dical	Beatrice Hile	da Barr					Septem	ber 26,	1999	6:40pm	
niner	4e Facility Neme (If not institution, give	street end number)			1		Location of Death	4c. County	of Death		
	Hebrew Home of G					Rockvil			gomery		
al or	Social Security Number 218-52-7688 6. Sex 1 M 2 F 96 Yrs. last birthdey) If Under Months					If Under 24 Hrs Hours Min	8. Date of Birt (Month, Da Februar	y 14,190	9. Birthplaca (Country) 3 Was1	State of Foreign	
_	Usuel Residence of Decedent		10. 00. 7						1000		
h-	10a. State 10b. County			own or Location						side City Limits	
5	Maryland Montgor	nery	Rockv							Yes 2□No	
ai Director	10e. Street and Number 10f. Zip Code 20852					2		10g. Citizen of W United			
by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detes:		13. Wes Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 Yes 2 No Specify:				or No- ic.) 14. Race - American Indien, Bleck, White, etc. Specify: White			
Completed	15. Decedent's Ed (Specify only highest grad	ucation	10	Sa. Decedent's	Usuet Occup	ation during most of wo	dkina	16b. Kind of Business/Industry			
출	Elementery/Secondery (0-12)	College (1-4or 5	+)]								
5		1	1 Scho		eache:	r/Homema	ker	Education			
Be	17. Fether's Neme (First, Middle, Last)							lle, Maiden Sumame)			
2	Jacob Levi	a				Sar	ah Rogin	ski			
	19e. Informent's Name/Reletionship (7)	ype, Print)	1	9b. Mailing Add	lress (Street	and Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)	
	John R. Barr/Son	n	1	5028 We	11woo	d Rd. Si	lver Spr	ing, MD	20905		
	20a. Method of Disposition	CVI II. III.	20b. Plece	of Disposition	(Name of		Date	20c. Location -		tete	
	12☐ Burial 2☐ Cremetion 3☐ I 4☐ Donetion 5☐ Other (Specify,			Israel			9/28/199	/28/1999 Washington DC			
1	21. Signature of unerel Service Licens		-	22. Nam	e and Addre	ss of Facility T	akoma Fu	norel Ue			
	NI. s	-0.1	,			1.	Washingto				
d	Benny U.	0000	صيوب				_			· Providence	
1	23 Party. Enter the disease, or comp	one ceuse on each lin	10 000(II. D	O HOL GINEET ING	mode of dyr	ig, such es cardia	C or respiratory ar	rest,	Inter	oximete val Between at and Death	
	Immediate Course (Final	1-1	-1-2	444	-	1 0	75		Olise	n and Death	
	Immediate Cause (Final disease or condition CEREREBRAL THROMBOSIS 3 DAYS										
_	Due to (or es a consequence of):										
edical Examiner		BATHE	ROS	CLER	2081	S			1/2	TARC	
2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Cause (Disease or injury) Cause (Disease or injury)										
ì										AR5	
2	Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of):										
	resulting in Death) Lest										
Physician/M		d		-					1		
흥	Pert II. Other significant conditions co	entributing to death bu	ributing to death but not resulting in the underlying cause given in Part I.				23b. Did 1	23b. Did tobacco use contribute to the cause of death			
É	Strategy of Godin but not resulting in								Yes 2 No 3 Probably 4 1 Unknow		
2											
Completed						performed? available comple			topsy findings prior to on of cause		
									of death		
							101	res 2 1 No	1 ∐ Yes	2□ No	
ום	25. Wes case referred to medicat examiner?	Hospital:			Oth		ath (Check only o	ne)			
2	1 Inpatient 2 EN Outpatient 3 DOA					ther: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)					
- 1	27. Manner of Death	28e. Dete of Injur (Month, Day	Yeer) 28t	28b. Time of Injury		y et k?	28d. Describe how injury occurred		ed		
- 1	1.26Naturat 5 ☐ Pending	M 1 Yes 2 No									
1	1 Anaturat 5 Pending investigation	1	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
- 1		28e. Plece of Inju	iry - At home, :. (Specify)	16111, 311001, 16	otory, omoo			m, State)			
Certification:	2 Accident 3 Suicide 4 Homicide 29e. Cartifier 2 Accident investigation 6 Could not be determined	28e. Plece of Inju	f my knowled	ge, deeth occu	red at the tin		City or Tox	cause(s) end me		ause(s)	
ledical Certification:	2 Accident 3 Suicide 4 Homicide 29e. Cartifier (Check only one)	28e. Plece of Injubuilding, etc yaiclan: To the best of	f my knowled	ge, deeth occu	red at the tin	pinion, deeth occ	e, and due to the curred et the time,	cause(s) end me date end place, a	and due to the d		
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Medical Certification:	2 Accident 3 Suicide 4 Homicide 29e. Cartifier (Check only one) 29b. Signeture end tille of person who co	28e. Plece of Injubuliding, etc. valcian: To the best of and menner ste completed cause of december 250 N	f my knowled examination led.	ge, deeth occur and/or investiga MD (Type, Print)	rred et the tim tion, in my o	pinion, deeth occi e number	e, and due to the curred et the time,	cause(s) end medate end place, a 29d. Date signed	and due to the di	Year)	



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month BURTON **Physician** ERICA 36AM /Medical 3001 HOS PITALAb. City, Town, or Location of Death 4c. County of Dea 4a Facility Name (If not institution, giva street and number) Examiner PRINCE DRIVE CHEVERU PRINCE GEORGES HOSP. CTR. GEORGES If Under 24 Hrs. 8 Date of Birth Hours Min. (Month, Day, 5. Social Security Number 6. Sax Birthplace (State or Foreign Country) 7. Aga (In vrs. last birthday) **Funeral** 1 M 2 F MAY Director None Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d, inside City Limits 1 Tyes 2 No TEMPLE HILLS PRINCE GEORGES Director "natural", or items 23s or 28s-f 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 2703 OXON RUN DRIVE 20748 U.S.A Funeral Pegas 1 and 2 should be filed within 72 hours after death nent of Health and Mentel Hygiens. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 21 No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TNEANT INFAN. INFANT NUNE - INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ERIC ROSE BORO SHANNON SHANTE BURTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DRIVE, CHEVERLY MD 20785 3001 HOSPITAL P.G. HOSPITAL CENTER Haalth em 27 i Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Memoval from State 4 Donation 5 Othar (Specify) Name and Address of Fa 21. Signature of Funeral Service biom 25 wher the disease, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest or haart failura. List only ona cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner GESTATION, 23-74-WKS Examiner end I-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last physician e STAPHYLOCOLCAL Physician/Medical Due to (or as a consequenca of) attanding esn 23b. Did tobacco usa contributa to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by the 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy irector, page 2 s 1 Yes 1 Yes 2 No 2 No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residance 6 Othar (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatiant 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural iniun 2 🗆 No 1 Yes 2 Accident 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

1 Cartifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the cause(s) and manner stated.

29c. Licansa number

29d. Date signed (Month, Day, Year)

The law requires that the death cartificate be executed P.O. Box 68760. Division of Vital Records.

with the Manyland

Baltimore,

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this cartifica complately filled in by the funeral director,

State Registrar

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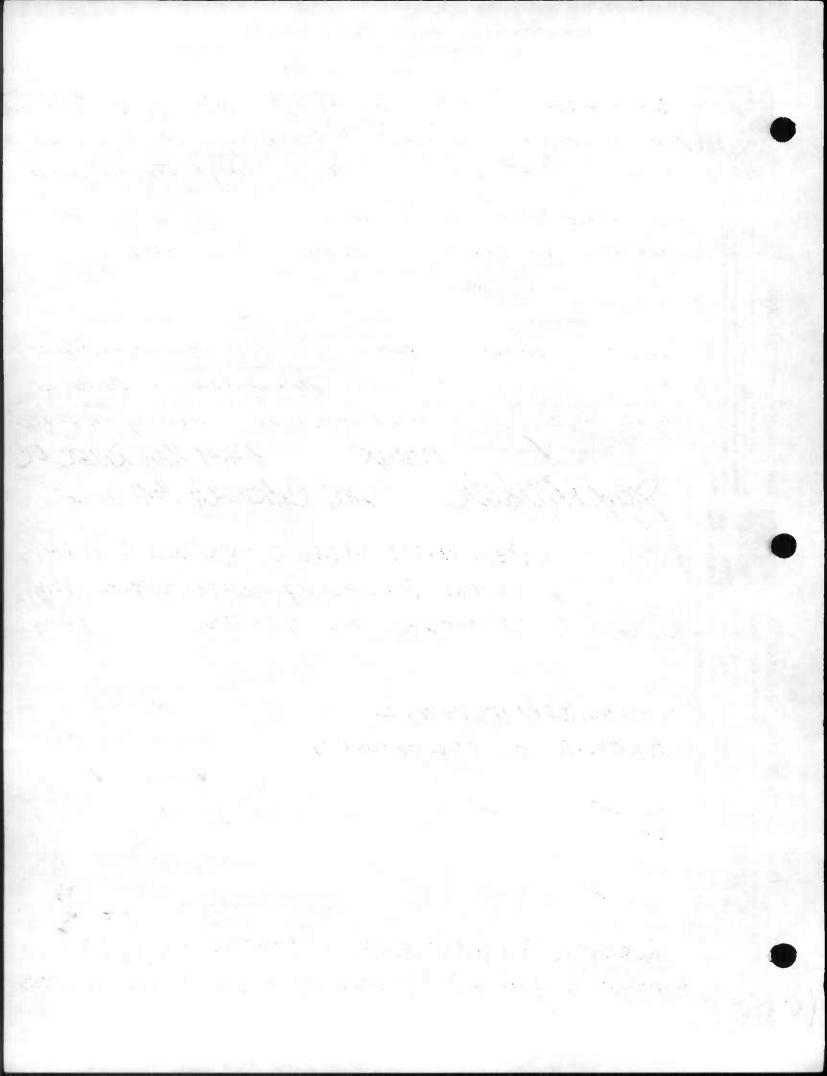
29a. Certifier (Check only one)

29b. Signature and title of certifian

31. Date filed (Month, Day, Year)

30. Neme and address of person who completed ceuse of deeth

NFOD 32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Physician JOSEPHINE BARBARA BAROCH October 6 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Fallston General Hospital Fallston Harford If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) JUNE 19, 1921 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Deys Hours Marykand 220-01-5520 78 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Jeffrey Terrace, Apt. A 21015 U.S.A. deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☑ Merried 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Year or Detes: Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. Int: If item 27 is marked other than "I ury or other traumatic avent, the Hee Elementery/Secondary (0-12) 12th grade College (1-4or 5+) Sales Department Store Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Grill Josephine Cada 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Jerome P. Baroch (Husband) permit. Pages 1 and Department of Heelth Important: If Itam 27 any Injury or other tr once. 1105 Jeffrey Terrace, Apt. A. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 10/9/99 Baltimore, Maryland 22. Nome and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee Celle 610 W. MacPhail Road, Bel Air, MD. 21014 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Electromechamical D /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner wara sevine sician and burial-transit The law requires that the death certificate be assecuted Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. à Be Completed 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: director. 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Menger of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturel 5 Pending Investigation 1 Yes 2 No 24 hours after deeth.

Funeral Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homleide Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner steted. 29e. Certifier (Check only one) within 2 \$ 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16444 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 2112 Belai Road. Fallston. MD21047.

DHMH 16 Rev 6/95

State Registrar

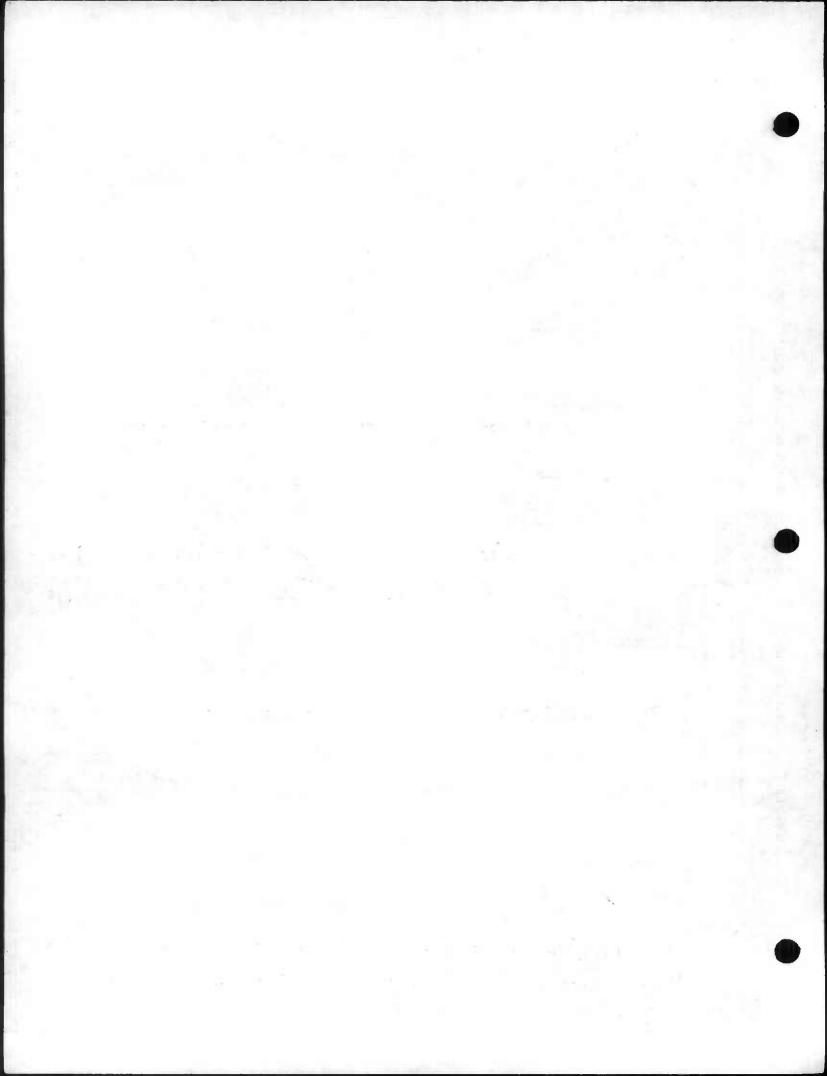
VIJAY. S. NAIR.

31. Dete filed (Month, Day, Year)

OCT 8 1999

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32. Registrer's Signetifie



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death OCTOBER 3:50 PM Dean Bowman 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death mde Arunde OCTH SURNIC 8. Date of Birth (Month, Dey, Year) May 27, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 40 217-78-2889 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7742 Woodlawn Ave. 21122 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No It Yes, Give Year or Dates: 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Port of Baltimore Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Clyde Bowman Carolyn McCoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) (Spouse) Pamela E. Bowman 7742 Woodlawn Ave. Pasadena, Md. 21122 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/6/99 Baltimore, Maryland 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 ication what caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ause on each line. 23a. Pert1. Enter th Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCINAR ACCIDENT Due to (or es e consequence of) LIVER FAILURE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3€ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 25. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 5 Other (Specify) 1 Yes 2NNo 1 Conpatient 2 ER/Outpatient 3 DOA 27. Mannerof Death 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 TYes 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifian 🕊 Certifying Phystcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examtner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours e To the within 2

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Pages 1 and 2 should be filed within hert of Health and Mental Hygienn. Int: If them 27 is marked other than ".

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30 Hours 32. Registrer's Signature

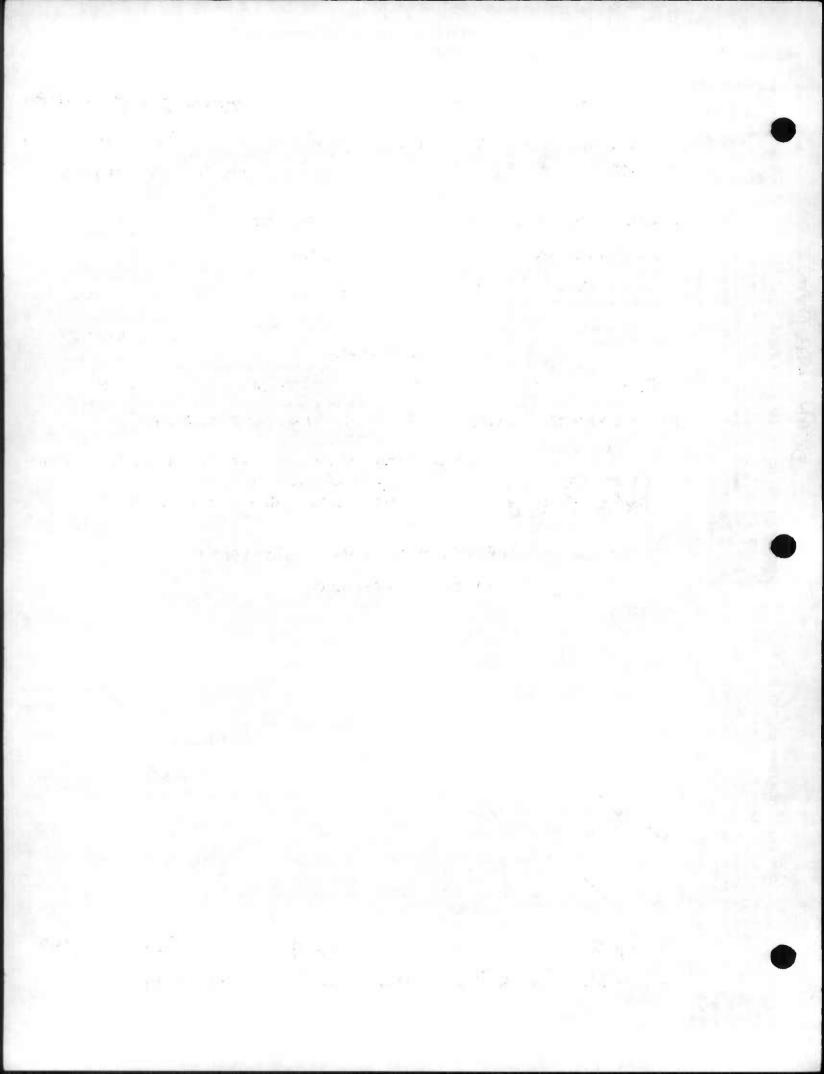
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANNE BUSER 07 1999 10 7:15 AM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Joseph Nursing Home Catonsville Baltimore H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 21, 1901 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 M 2 F Months Days Director 220-24-5654 Maryland Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23s or 28s-f show traumstic event, the Medical Examiner must be notified at MD Ellicott City Howard Director 1 ☐ Yas 2 N No 10a. Street and Number 10f Zip Code 10g. Citizen of What Country? 21043 2902 Chestnut Hill Drive USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 72 hours after 1 Never Merried 2 Married 1 Yes 2 No
If Yes, Give
Yeer or Dates: Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 7: I Hygiene. other then "ru Elementery/Secondery (0-12) College (1-4or 5+) Housewife Own Home permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Importants if them 27 is marked other the any injury or other treasments. 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augusta D'Shav Louis Klein 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 2 Summit Hill Court B2, Catonsville, MD Dorothy B. Hall (Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete New Cathedral 10/11/99Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fulneral/Service)Licensee 22. Name end Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 232 Part L Entr. La Storm contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mode, or having failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Examiner un clever attending physician and for use as the bunishmen Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use pontribute to the cause of death? 1 | Yes 2 I No 3 | Probably 4 | Unknown þ 8 24b. Wera eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funerel Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be datamined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of tnjury - At homa, farm, street, fectory, office building, etc. (Specify) 4 I Homicide 16 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) end manner stated. 29a. Cartifiar (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

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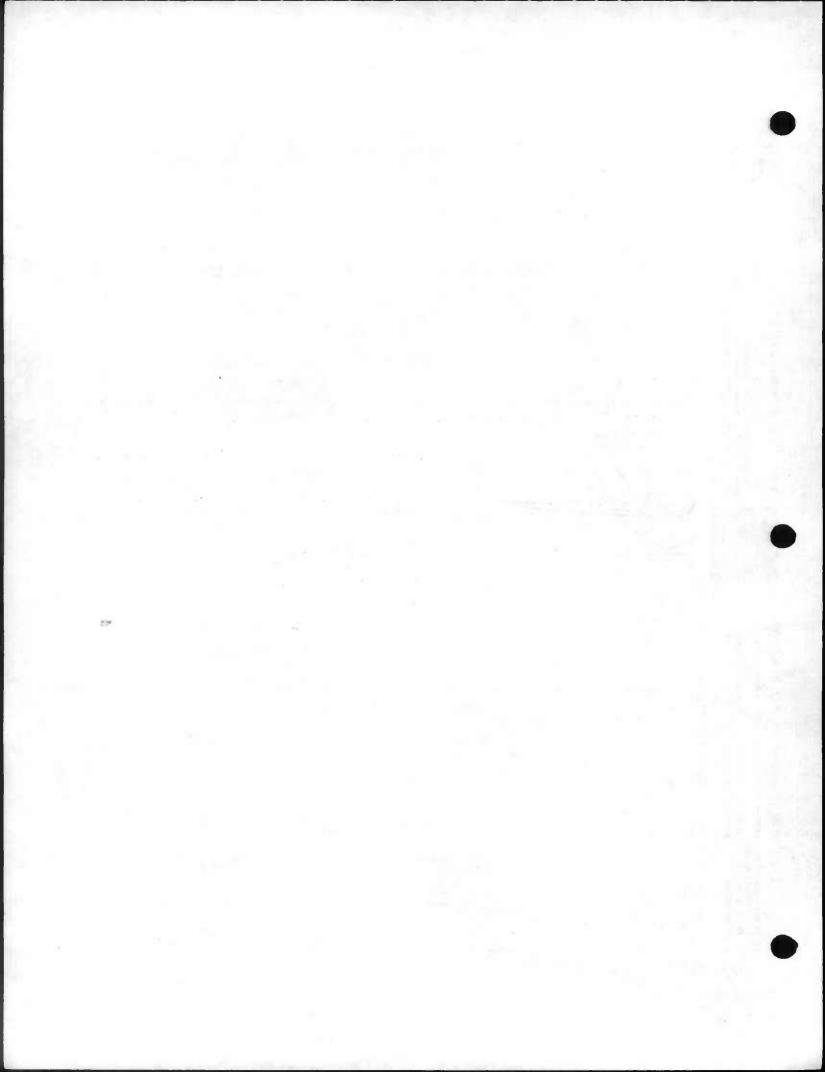
youde

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4. Sparks

D0008780



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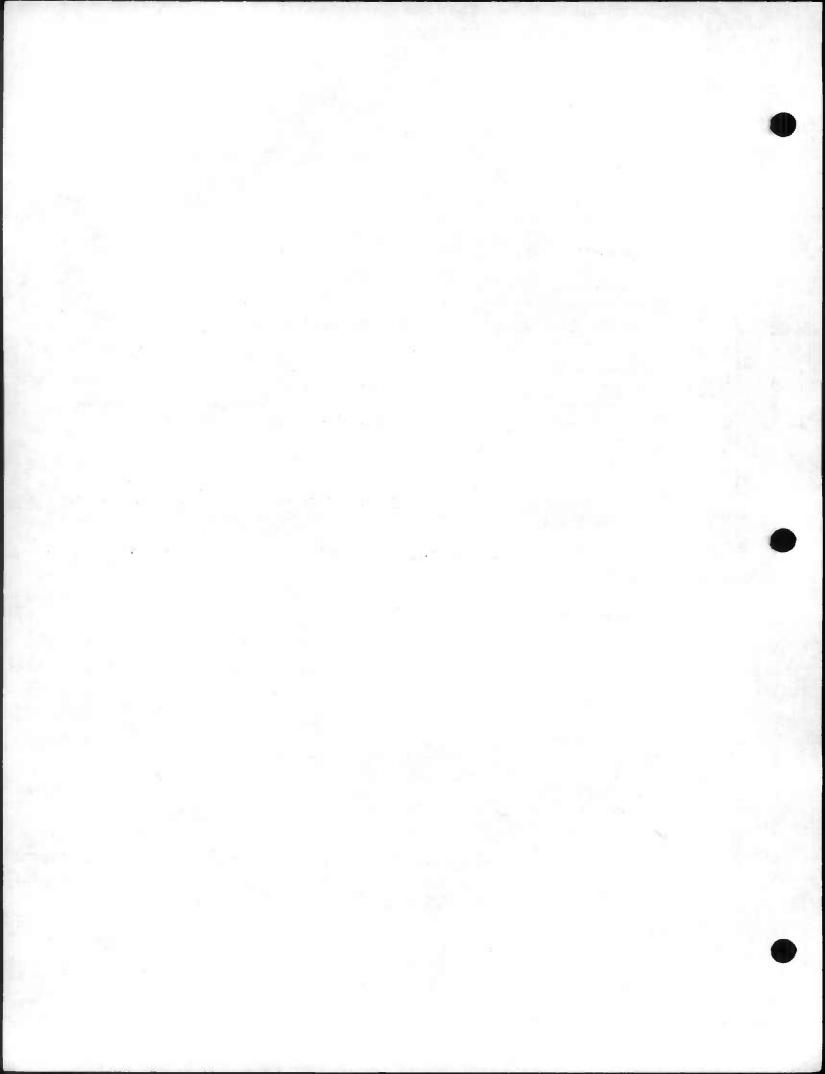
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 5, 1999 Physician 7:52 PM MARTIN BAZENSKY /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, giva street and number) 4c. County of Death Examiner GILCHRIST CENTER - HOSPICE OF BALTIMORE TOWSON BALTIMORE If Under 24 Hrs. If Under 1 Year 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 215-50-5401 51 Director APR.6, 1948 MD Usual Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f show BALTIMORE BALTIMORE 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8247 STREAMWOOD DRIVE U.S.A. 21208 Items 23a death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? ARMY 1 Mays 2 □ No If Yes, Give Year or Detes: RESERVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 72 hours after 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PATIO permit. Peges 1 and 2 should be filed within Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event. In a Mental Intelligent Intelligent Intelligent Intelligent Intelligent Intelligent Intelligent Intelligent Intelligent Elementery/Secondary (0-12) College (1-4or 5+) OWNER DISCOUNT DINETTE & 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SIDNEY BAZENSKY RAE FELD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) MIRIAM BAZENSKY / WIFE 8247 STREAMWOOD DRIVE - BALTIMORE, MD 21208 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 10/7/99 REISTERSTOWN, MD 21. Signetura of Punerel Sarvice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset end Death **Physician** ostatic adenocancinous Two years /Medical Immediate Cause (Finei disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): 980 the ? 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by to 1 | Yes 2 No 3 | Probably 4 | Unknown ģ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 TRNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation hours efter death. 1 ☐ Yes 2 ☐ No 2 Accident an 24 hour.
the Funeral Director of the Funeral Direct 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide vithin 24 hour 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. edical 29e. Certifier completely (Check only one) 29b. Signeture and title of certifiar 29d. Date signed (Month, Day, Year) October 5, D17873 Charles H Towson, MD 21204 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) Marghall A. Levine 65-69 North

State Registrar

31. Dete filed (Month, Dey, Year) 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Sophie Serma

4a. Fecility Name (Fnot institution, give street and number) Berman 2:18 PM October /Medicai 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys 214-20-6269 85 Yrs. Director AUG.9,1914 Usuel Residence of Deceden the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at BALTIMORE WOODLAWN 1 ☐ Yes 2X No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8329 MINDALE COURT 21244 U.S.A. #D death 12. Was Decedent Ever in U,S.
Armed Forces?

1 ☐ Yes 2 ▼No 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiena. Insportant: If Item 27 is merked other than "natural", or iter enty injury or other traumatic avant. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify p 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education 16e. Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondery (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be LOUIS REISER REBECCA FEIT 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JOAN BERMAN / DAUGHTER 2222 CAVES ROAD #B - OWINGS MILLS, MD 21117 altimore. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BREW YOUNG MENS 10/6/99 WOODLAWN, MD 4 Donation 5 Other (Specify) 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, and on each line. Approximate Intervel Between Onset end Death **Physician** /Medicai Immediate Cause (Finel . Multiple organ system disease or condition resulting in death) Examiner Physician/Medical Examiner response syndrome bunal-transit certificata be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or InJury that initieted events resulting in death) Lest and 68760. the attanding physician Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 2 1 Yes 2 No 3 Probably 4 Unknown Chronic renal failure Records, 24b. Were eutopsy findings evailable prior to Be Completed 24a. Wes en eutopsy Transitional cell carcinoma of the bladder completion of cause of deeth? The law page 2 certificata has Congestive heart failure

25. Was ode referred to medical
exeminer? 2 No 1 Tes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menger of Death 1 Natural 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D28462 October 3, 30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Center 5401 Old Court Road

State Registrar Northwest

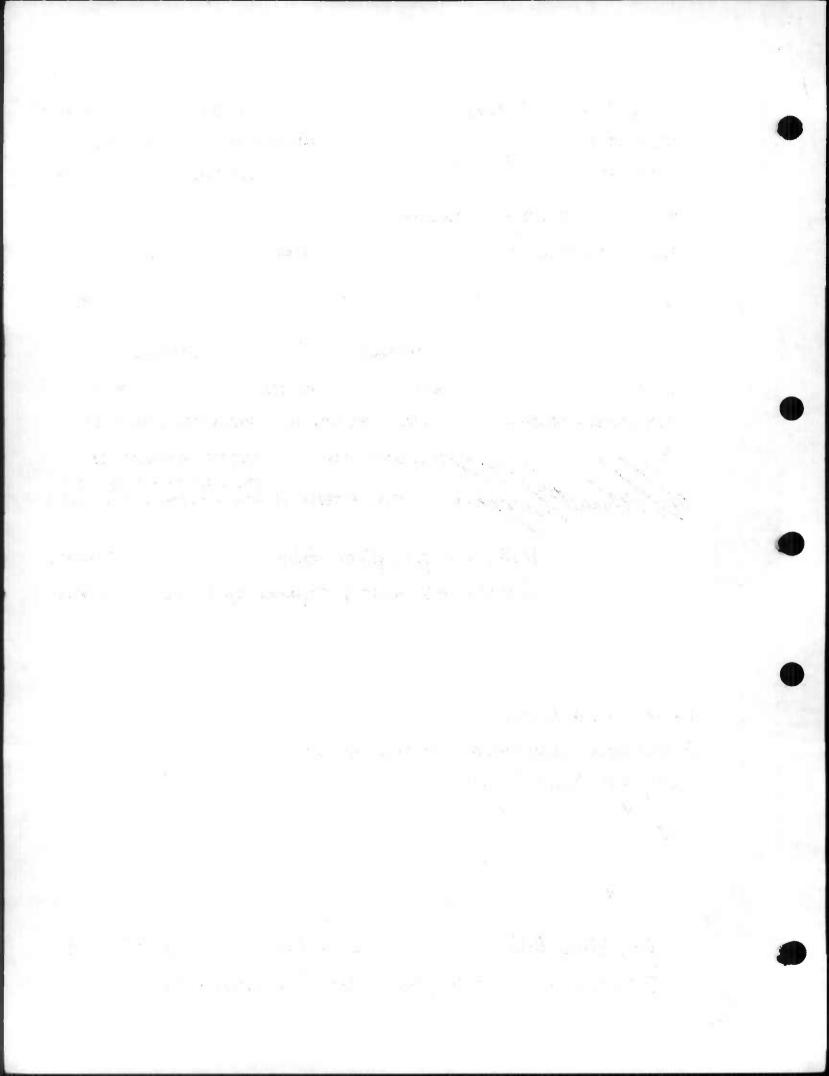
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32 Registrer's Signeture

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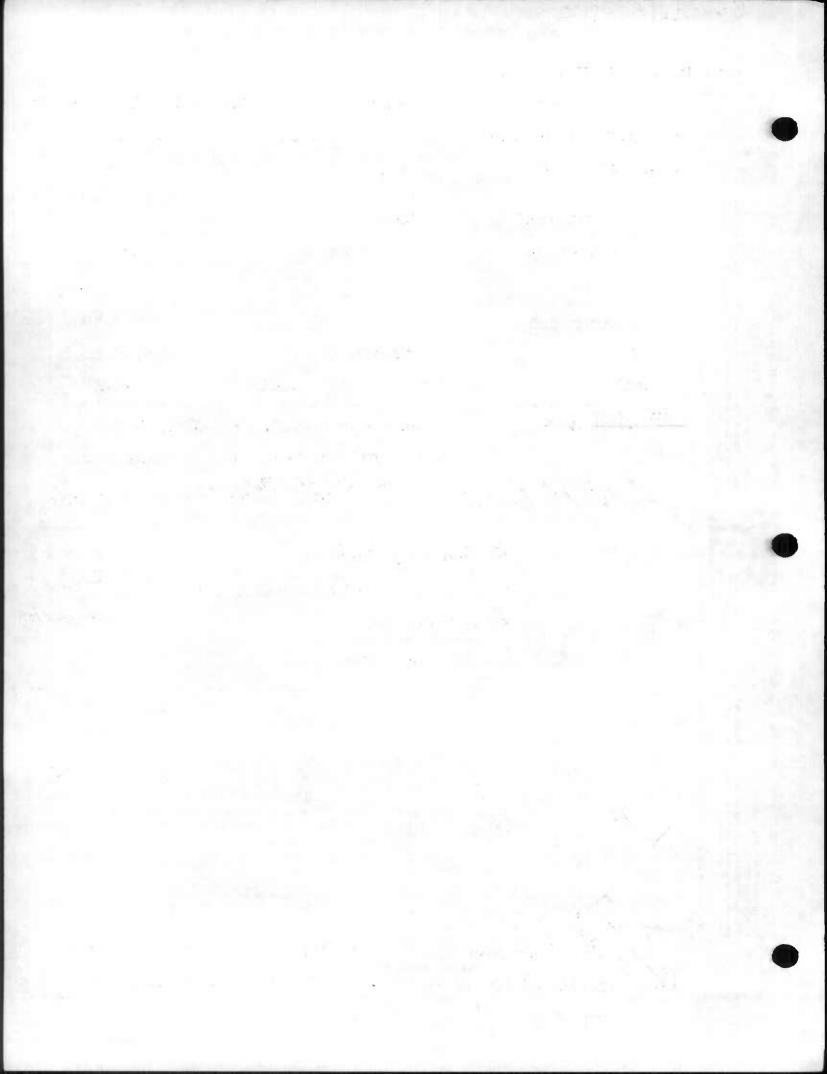
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31. Dete filed (Month, Dey, Year)



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uneral irector		5. Social Security N 215–14–6	Number 6.		ge (In yrs. lest i	birthday) If Under 1 Year Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Dey, 12-9-22	Year)		place (State or Foreig	
affer death with the Maryland or items 23a or 28a-f show miner must be notified at		Usual Residence o 10e. State	f Decedent 10b. County		10c. City, To	wn or Location					10d. Inside City Limits	
	etor	MD	MONTGO	MERY		ROCKVILLE					1 □Yes 2 □ No	
	I Dire	10e. Street and Nu 18127 BC	mber OWIE MILL	RD		10f. Zip Code 208	355	10	g. Citizen of \	What Cou USA	ntry?	
	by Funeral Director	11. Maritel Status 1 Never Marr 3 Widowed	ied 21 Married	12. Wes Deceden Armed Forces 1 Yes 20 If Yes, Give Yeer or Dates	?] No	13. Was Decedent of If Yes, specify Cul		ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. WHITE	
	leted	(Spec	15. Decedent's E	ducetion ede completed)	16	ia. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	a during most of work	ing	6b. Kind of Bu	usiness/Ir	ndustry	
	Completed	Elementery/Second 12 17. Fether's Name		College (1-4or	5+)	BUILDING CC		e (First, Middle, N	CONST		CION	
or other traumatic event, the Me	To Be	KOPEI		RACHE	ACHEL BRAVE							
The control of the co	cian dical diner Examiner	60	23e. Pert1. Enter shock, or head in the distance of condition resulting in death) Sequentially list or if any, leading to incause. Enter Undurant initiated event resulting in death)	(Final on onditions, mediate bertying injury s Lest	a. Res	Due to (or es Due to (or as Due to (or as Due to (or as	22 Name and Add SOL LEVI 8900 REI on not enter the mode of dy a consequenca of): A REI (Consequence of): Culul a consequence of): Culul a consequence of):	Anec	RD. PII or respiratory arre	KESVILI ist,		Approximate Intervel Between Observed Between Observed Between Observed State
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	mpleted							24a. Was ai perform	ned?	0	Vere autopsy findings vailable prior to ompletion of cause f deeth?	
director, page	Be Co	25. Was case reference examiner?	rred to medical				26. Place of Deel	th (Check only on		'	2165	
ral dire	2	1 Yes 2	1	Hospital: Inpar		Outpatient 3LI DOA		ome 5 Reside			ify)	
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	edicai	29a. Certifier (Check only one)			of examination	ge, deeth occurred at the and/or investigetion, in my						
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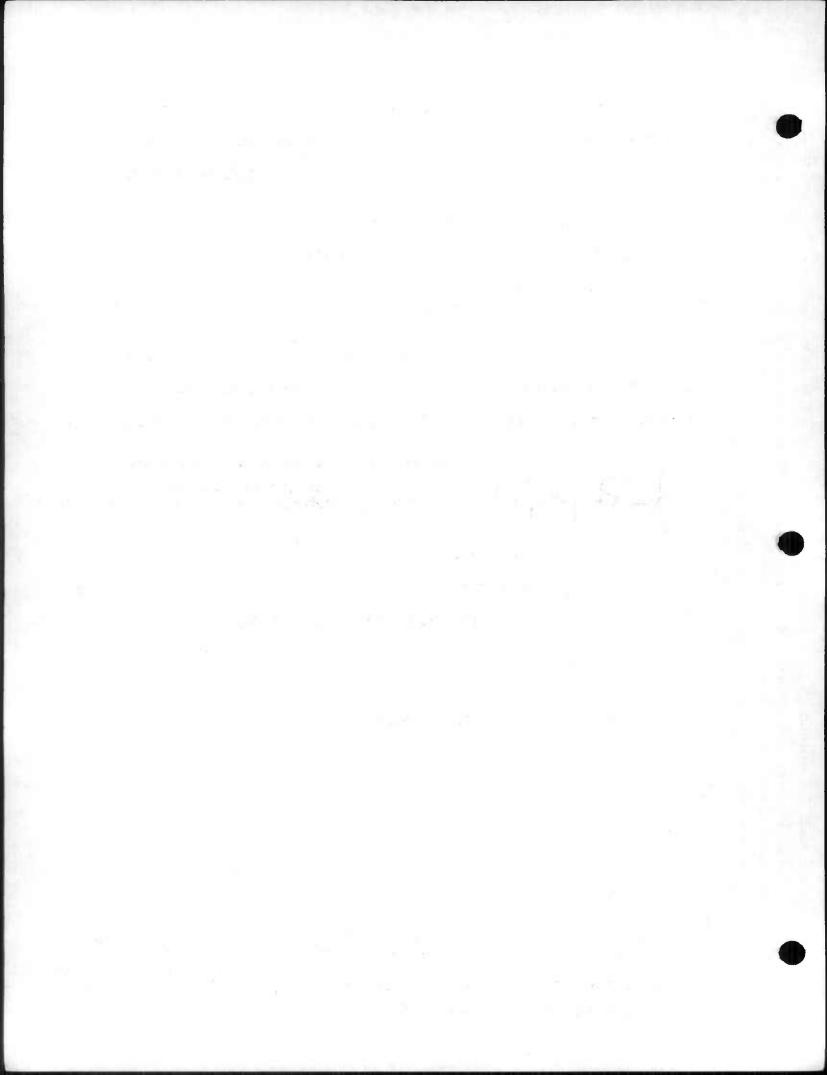
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/Medical Examiner		Immediate Ceuse (Final disease or condition rasulting in death) Hypercalemia										2 months	
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tel or Attendin s efter death. Il Director: Aft ed in by the fur	Certific	3 Suicida 6 Could not b 4 Homicide datarminad	28a. Place of Inju- building, etc.	ry - At homa, fa (Specify)	rm, strae	at, factory, of	ffice		28f. Location (S City or Tow	traat and Numbe n, Stata)	r or Rura	l Routa Number,	
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		30. Name end address of person who				•	1	, हार्य	Walte	r Reed A	army	Medical C	
Sta		Alfred B Brooks M 31. Date filad (Month, Dey, Yaar)	32. Ragistra	∠-1813 's Signatura					d. loth	DI NW Wa	snır	igton DC	
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G. Sparks

DHMH 16 Rev 6/95

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Physician /Medical Examine The law requires that the death certificate be executed physician s the buriel P S page 2 Attending Physician: chis After 24 hours after death. filled in by Hospital completely within 2 \$

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

within 72 hours efter

Hygiene.

permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Nem 27 is marked oft any Injury or other treumatic even once.

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

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Funeral

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2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29a, Cartifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year) 32. Registrar's Signature OCT

30. Nama and eddress of person who completed cause of death (Itam 23a) (Type, Print)

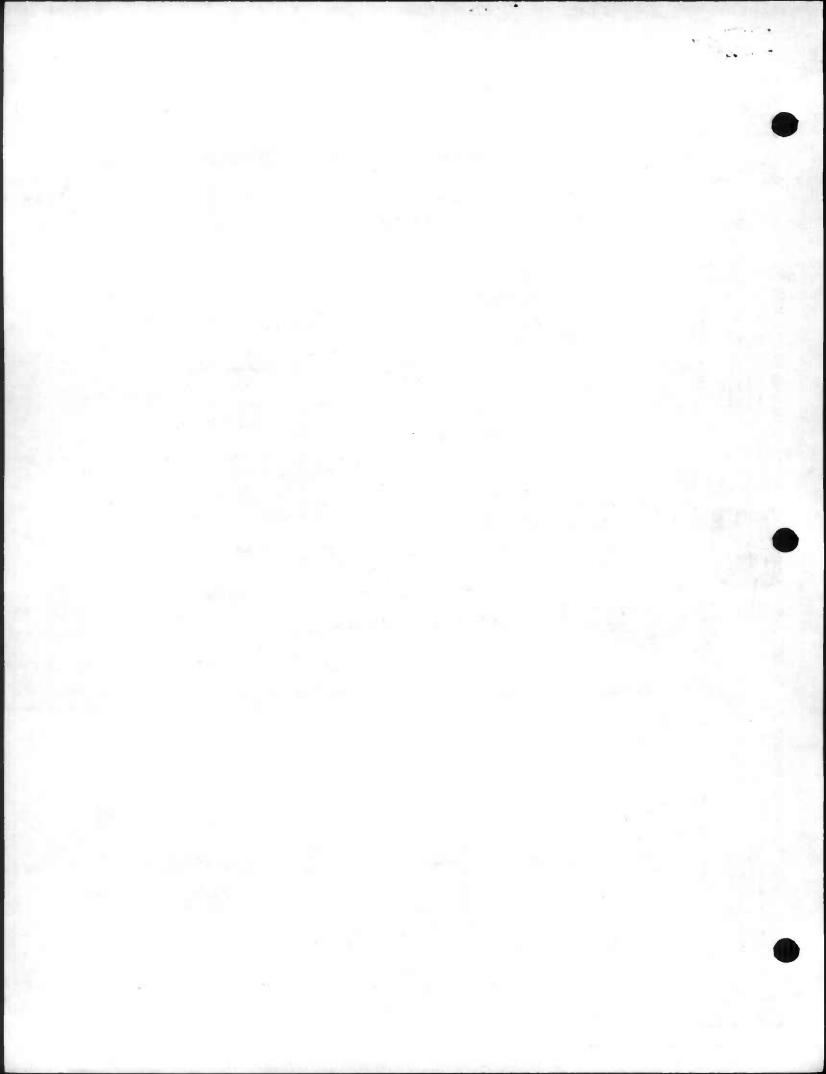
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Dr. Magan Pansuriya

Westminster, Maryland 21157 419 Malcolm Drive

D 51703

October 1, 1999



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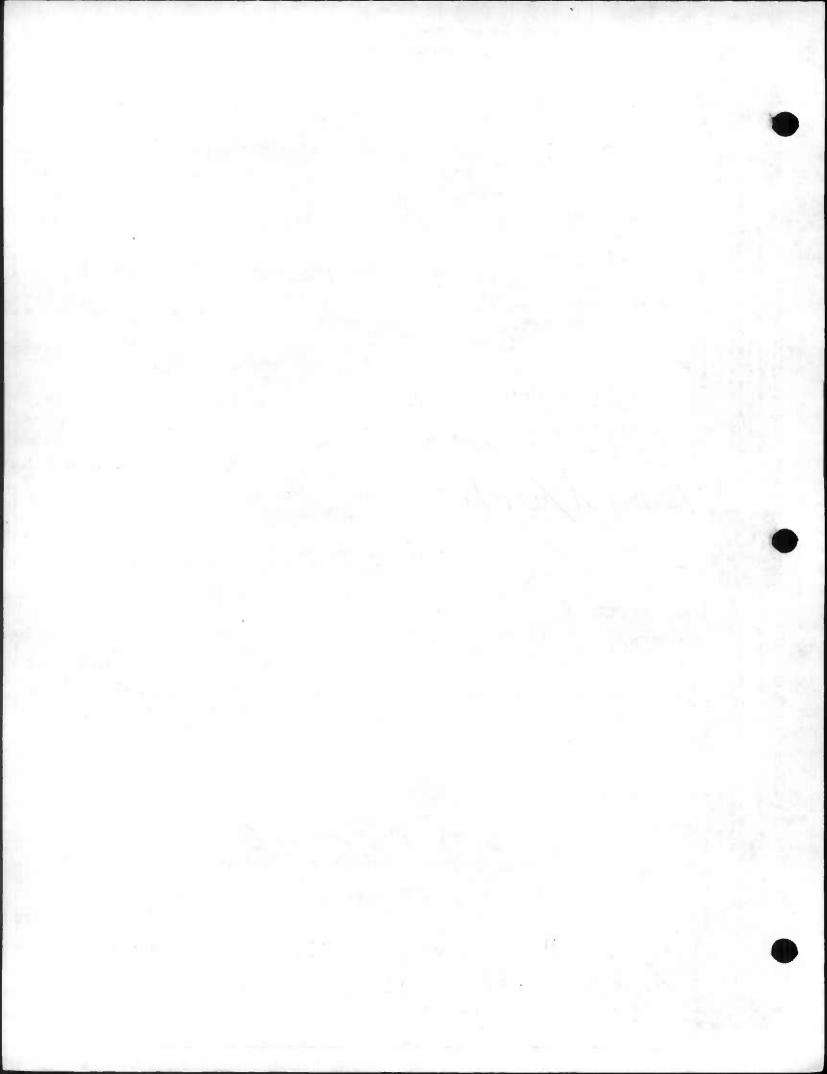
		State of Maryland / Department of Health and M Certificate of Death	ental Hygiene 9 9	31543								
	Physiciar /Medica	1. Decedent's Neme (First, Middle, Last) William Virgil Crider, Jr.	2. Date of Death Month October 6, 1999	3. Time of Death 11:00 PM								
	Examine	St. Agnes Nursing & Rehabilitation Center 4b. City, Town, or Loc Ellicott	cation of Death 4c. County of HOW	Death Vard								
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	Meryland a-f ahow find at	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🕅 No								
	ter deeth with the Merylan thems 23a or 28a-f show from mast be notified at	MD Baltimore Catonsville 106. Street and Number 34 Holmehurst Avenue 107. Zip Code 21228 USA USA 11. Meritel Status 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Bleck, White, or or No-Blec										
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Baltimore, Maryland 21215-0020	be filed within 72 ho tel Hygiene. d other than "nature avent, or wedge.	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Finance Officer		ness/industry								
and		17. Father's Neme (First, Middle, Last) William V. Crider, Sr. Jenn	(First, Middle, Maiden Sumeme) ie Reichard									
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re, N		Carolyne K. Crider/wife 34 Holmehurst Avenu 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date 20c. Location - Ci									
imo		4 Donation 5 Other (Specify) Metro Crematory, Inc. 10/1		ce, MD								
Ball	permit. Pe Departmen Important any Injury phcs.	21. Signeture of Funerel Service United 22 Name and Address of Facility MacNabb Funeral Edward A. Gregorchik 301 Frederick R	d. Baltimore	, MD 21228								
S	Physician	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart feilure. List only one cause on each line.	r respiretory arrest,	Approximate Interval Between Onset and Death								
	/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) Culturons of lury		postls								
	2 % G	Due to (or as a consequence of):										
,0928	cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C.		1								
Box 687	seth certificate be attending physicia for use as the bur clan/Medical	resulting in deeth) Lest Due to (or es e consequence of):										
.O. Be	D 0 0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contr	ribute to the cause of death?								
4	igned by the be detached by Physical by Ph		1 Yes 2 No 3	B Probably 4 Unknown								
Records,	s been s 2 should		24a. Was an autopsy performed?	24b. Were eutopsy findings evailable prior to completion of cause of death?								
al B	ystclen: The lay s contificate has director, page 2		1 ☐ Yes 2 No	1 Yes 2 No								
of Vital		26. Place of Deeth examiner? 1 Yes 2 No Other: 4 Nursing Hon	n (Check only one) me 5 ☐ Residenca 6 ☐ Other	(Specify)								
ion o	Attending Ph or deeth. ector: After thi by the funeral		28d. Describe how injury occurred									
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	within 24 hours a To the Funeral Completely filled	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, e 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, e	and due to the cause(s) and menned at the time, date end plece, an	ner as stated. Indicate due to the cause(s)								
	Total Com	29b. Signature and title of certifier 29c. License number	29d. Date signed (
	Mer	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		7, 1999								
	V 1	CHARLES R. GRAHAM 1001 PINE HGTS AV 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature	E BALTO. M	D. 21229								
	State Registrar	OCT_ 8 1999 Drewa &										

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		Flease	State of Marylan	nd / Department of Certificate of	f Health and M	ental Hygie	ene q q	31	544		
	Physician /Medical	Decedent's Nama (First, Middle, La Mary Vincent C	allahan	- Commodic C		2. Deta of Death Month October	ber 4, 1999 12:10				
	Examiner Funeral Director	377-00-0770	are Center	Months Da		of Deeth CIMOR 9. Birthplac Country) CONN					
11215-0020 within 72 hours after death with the Maryland and: than "retural", or flores 23e or 28e-4 show he leaded at the Maryland at the Mar	or 28a-f show be notified at Director	-	timore 10c. Cm	y, Town or Location Baltimore	A,				Inside City Limits 1 Yes No		
	r tems 23a or ther must be or Funeral Dir	10e. Street and Number 6401 North Cha. 11. Marital Status 1 □Never Married 2 □ Merried	rles Street 12. Wes Decedent Ever in U. Armed Forces? 1 Yes 2 No		212 of Hispanic Origin? (Spe Juban, Mexican, Puarto	υ.		- American	Indien,		
21215-0020 d within 72 hours af	yglana. Ner than "natural", or nt, the lead on Error Completed by	3 Wildowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	Year or Detas: ducation ide completed)	Year or Detas: Cation (Give kind of work done during most of life, Do NOT use retired)				Wh:	ite _{fry}		
CA D	d other avent, I	17. Father's Neme (First, Middle, Last, Vincent T. Cal		Teache	18. Mother's Neme	ial (School				
2 0	of Health f Item 27 r other tr	19a. Informent's Name/Relationship (Bernice Feiling 20a. Method of Disposition 112 Burial 2 Cremation 3 C	Type, Print) ger, SSND	19b. Meiling Address (Str. 6401 N. Ch	eet end Number or Rura arles St.	Route Number, C	City or Town, S	MD	21212		
Baitimore,	Department of Important: If It any Injury or one	4 Donation 5 Other (Specification of Funeral Service Items 21 Structure of Funeral Service Items 22 Sa. Part1. Enter the disease, or company shock, or heart leiture. List only	No ho	otre Dame Ce 22. Nama and Ad Mitchel 6500 Yo	dress of Fecility	ld Home			MD 212		
1	ysician Medical caminer	shock, or heart leiture. List only tmmediate Cause (Finet disease or condition resulting in death)	. Sobo	arachood 3				Int	oproximate terval Between nset end Death		
. Box 68760, death certificate be executed	attending physician and if for use as the burial-transit clan/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or es e consequence of):							
P.O.	d by the setached	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying cause	given in Part I.	23b. Did tobe			e cause of death?		
ecords	2 should					24a. Wes an a		availa	eutopsy lindings ible prior to lation of cause ath?		
on of Vital	leath. for: After this certific the funeral director cation: To Be	25. Wes case referred to medical examiner? 1 Yes	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M 28c. If	njury et Nork?	ne 5 Residence 28d. Describe how 28f. Location (Stree	injury occurre	r (Specify) ad	es 2 No		
Hospita	Funer faly fill	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno- niner: On the basis of axaminat and manner steted.	wiedge, death occurred et the	e time, date end place, e	City or Town, s	se(s) end mar	nner as state	od. e cause(s)		
To the	within 2 To the comple	29b. Signature and Affiliation Certifier	nolbert 1		ense number)28873	290	Date signed	(Month, De)	y, Year)		
E	State Registrar	30. Name and address of person who NEAL M. FATE (31. Date filed (Month, Day, Year) OCT 8 1990	32. Registrar's Signe	6565 N.	Charles S	it., Tow	son,	MD 21	1204		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #28a PER MD G776 10/13/99 AH 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Physician SAMUEL CARAVELLO 10.151 1999 10 6 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTO MOSPITAL COLP CHURCH If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6. Sex 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Funeral Days Months Hours 212-07-3739 96 Yrs. ITALY Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Director N/A BALTIMORE MD. must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a or 21224 648 S. DECKER AVENUE U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Stetus Bleck, White, etc. 1 Never Married 2 Merried 6 1 ☐ Yes 2 X No Specify: à 3℃Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondery (0-12) 1 2 College (1-4or 5+) RAILROAD LABORER 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental 1 mportant: If Item 27 is marked of JACK CARAVELLO JOSEPHINE MERLO 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) RICHARD CARAVELLO/ SON 21224 648 S. DECKER AVENUE, BALTIMORE, MARYLAND 20a. Method of Disposition
1XX Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) 10/9/99 HOLY REDEEMER CEMETERY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel SEPSIS. disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): death certificate be Physician/Medical Due to (or as a consequence of) signed by the attending of be detached for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PRE RENAL AZOTEMIA à ATRIAL PIBRILLATION 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? NOUND DEMERCENCE 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA Certification: 28c. Injury at Work?

Records, P.O. Box 68760 Division of Vital After death. ne Hospital or Attandi n 24 hours after death. ne Funeral Director: A

altimore, Maryland 21215-0020

27. Menner of Death

1 Netural

29s. Certifier (Check only one)

5 Pending investigetion

2 Accident 6 Could not be determined 3 ☐ Suicide 4 D Homicide

28a. Date of Injury (Month, Dey Year) NO /NOGE

omes MD

28b. Time of

1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and thie of certifier

29c. License number 20081977 29d. Dete signed (Month, Day, Year)

who completed cause of death (Item 23s) (Type, Print)

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BALTO ND ZIZZ/ ICHARCA HOSE/100 NBROADWAY,

Registrar

Medical

32. Registrer's Signeture

DHMH 16 Rev 6/95

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To the Hospital Within 24 hours To the Funeral Completely filled

The law requires that the death certificate be

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar trains be notified at

is 1 and 2 should be filed within of Health end Mental Hygiene. Item 27 Is marked other than

Department of H Important: If its any Injury or of once.

Physician /Medical

Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daeth 3. Time of Death **Physician** Month 12:00 pm Gertrude Emma Dailey October 5 1999 /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Augsburg Nursing Home Baltimore If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Yeer) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1□M 25√5 Months 219-12-7859 79 Yrs Director Feb. 2, 1920 Md Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limita Md -Baltimore n/a Director 15 Yes 2 □ No 10a Street and Number 10f. Zio Coda 10g. Citizan of What Country? 2131 Ashburton Street 21216 USA Funeral 12. Was Dacadent Evar in U,S. Armed Forcas? Was Dacadant of Hispenic Origin? (Specify Yas or No. If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien. Black, Whita, etc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1□ Yas 2□No Specify: Specify: Black þ 3 Widowed 4 Divorcad Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12th grade Janitor Supervisor 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be Ernest Johnson Alice Johnson P 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Michael Dailey 3826 Arbutus Avenue Baltimore, Md. 21207 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Surial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Oct. 9 Brooklyn, Md. 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service L 2501 Gwynns Falls PKWY Baltimore, Md. 21216 mus 23a. Part 1. Entar tha disaasa, or complications that causar the death. Do not entar tha moda of dying, such es cardiec or raspiratory errest, ahock, or haert failura. List only ona causa dryeach Approximata Intarval Batween Onsat and Deeth Immadiete Ceusa (Final diseasa or condition rasulting in death) TERMINAL LUNG CANCER 3months Due to (or as a consequence of) Physician/Medical Examin Sequantially list conditions, if eny, laading to immadiata causa. Entar Undarlying Causa (Disaase or Injury Due to (or as a consequenca of): that initieted avants rasulting in daath) Last Dua to (or as a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown INTRACRANIAL BLEED þ 24b. Were eutopay findings aveilable prior to complation of causa of deeth? Completed 24a. Was en eutopsy ABDOMINAL DISTENSION 2° LIEUS LATE FFFECT STROKE 1 ☐ Yas 2 ☐ No 1 TYas 2 No 25. Was case rafarred to medical axaminar? Be 26. Pleca of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Mursing Homa 5 Rasidanca 6 Othar (Specify) P 27. Manner of Daath 28a. Data of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury at Work? Certification: 28d. Dascribe how Injury occurred 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be detarmined 3 Suicide 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicida 15 Certifying Physician: To the bast of my knowledge, death occurred et the time, date and piece, end due to the cause(s) end manner es ateted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifiai Medicai 29d. Data signed (Month, Day, Year) 29b. Signetura and titla of certifian 29c. Licansa number October 5,1999 30. Name end address of person who complated cause of deeth (Itam 23e) (Type, Print)

Deborah I PIENCE 7220 F Park Heights Avenue Baltimore, MD 31. Data filad (Month, Day, Year)

State Registrar

8 1999 OCT

32. Registrar's Signature

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Box 68760. P.O. of Vital Records,

Division

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Importants: If Item 27 is marked other th any Injury or other traumatic event, the page.

Physician

Examiner

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> 29e. Certifier (Check only one) 29b. Signetyme and title of curtifies

4 | Homicide

29c. License number D20650

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner steted. 29d. Dete signed (Month, Day, Year) Oct. 5, 1999

BALTO, MD 21204

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

David D. Collins MD, 6701 N. Charles St.,

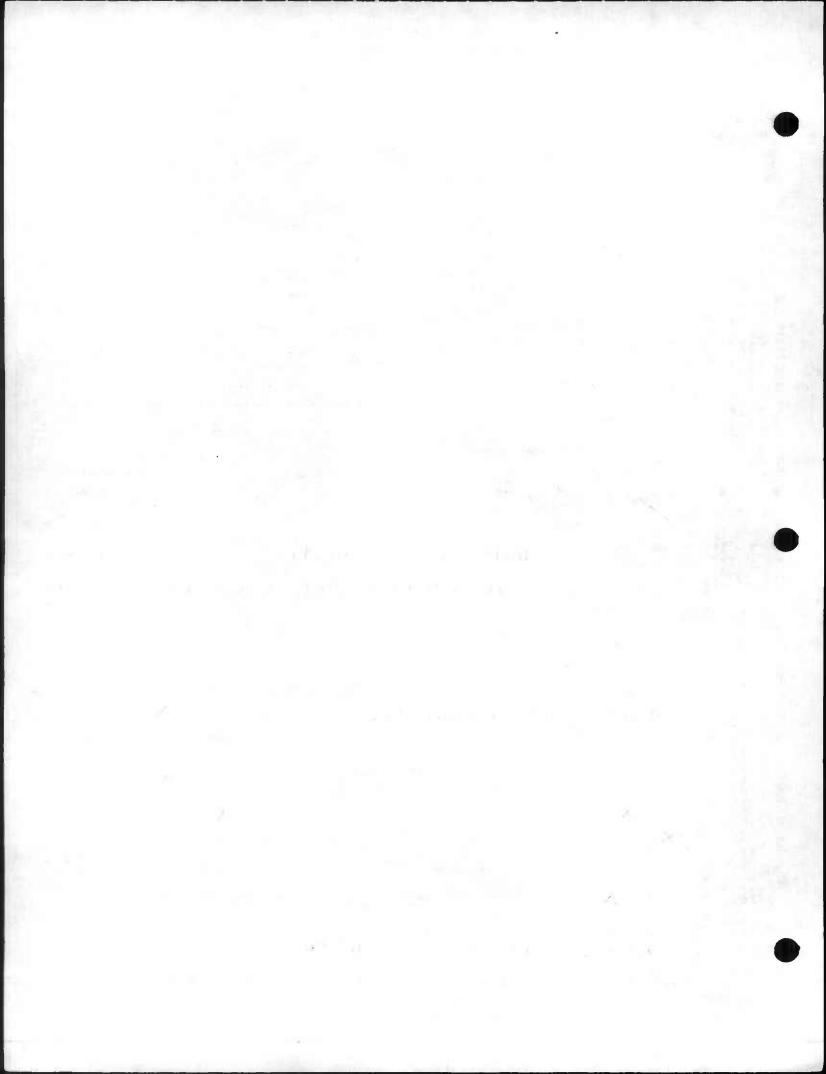
31. Dete filed (Month, Dey, Year)

8 1999

32. Registrer's Signature

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State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Patricia Lee Dietz OCTOBER 1999 00:25AM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Catonsville Baltimore If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days 1 M 2 X F Months 59 218-36-4617 June 1, 1940 **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Vista Mobile Drive 21222 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Giva 1 Never Married 2 Married 1 Type 2√ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) George Novak Veronica Kosmicki 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis G. Dietz Sr /husband Baltimore, MD 6 Vista Mobile Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 11 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Sacred Heart of Jesus 1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Nama and Address of Facility 21. Signature of Furnial Service Licenses Connelly Funeral Home of Dundalk 23a. Pant. Enter the disease or complications that caused the dealt of not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura is storily one cause on each line. Approximata Intervel Between Onset and Death hstructure Immediata Cause (Final ears disease or condition resulting in death) Dua to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Serzures 24b. Wera autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 1 Yas 25. Was case referred to medicat axaminer? / / 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 ☐ Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed P.O. Box 68760. Division of VItal Records. Attending Physician: ours after deau To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by the

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DHMH 16 Rev 6/95

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Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

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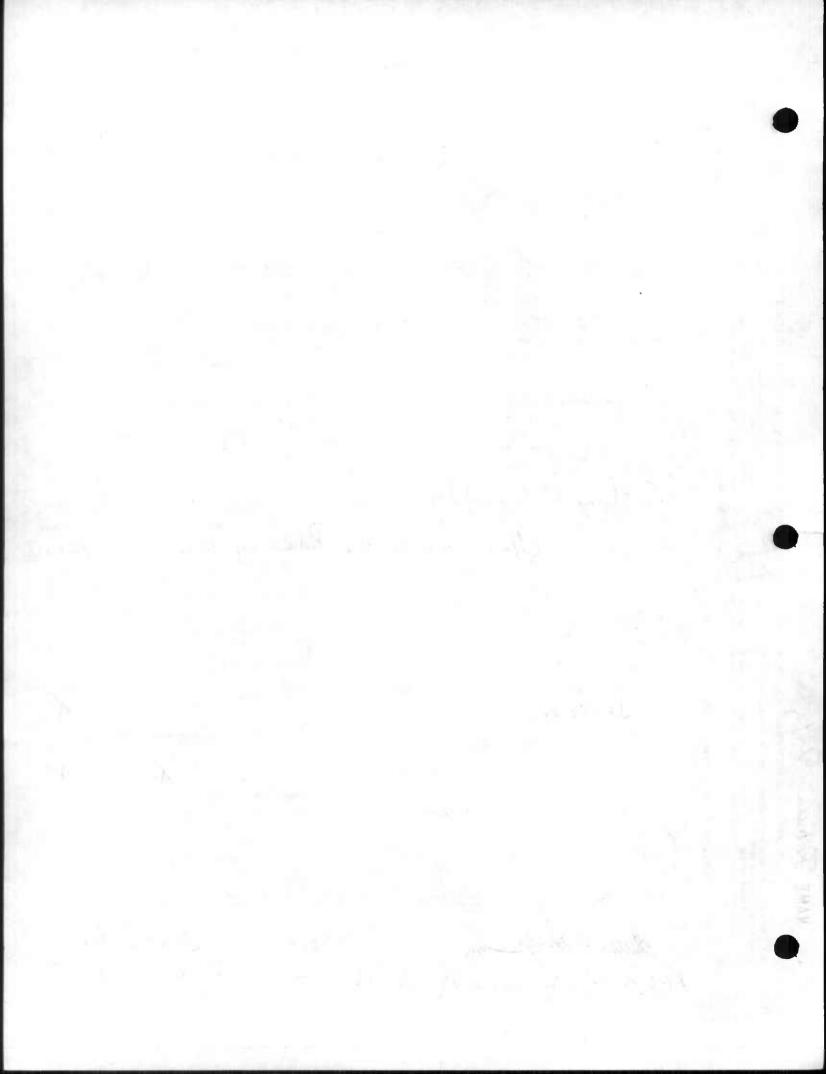
edical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated.

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29d. Date signed (Month, Day, Year)

frame Buthmore, Mary land

29c. License number



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		State of Maryland / Department of Health and	Mental Hygiene Q Q 3	1549
RT		Certificate of Death	Reg. No.	1072
- ysician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
nedical	Louis	Daubert	OCTOBER 6, 1999	1:45A.M

Ph Examiner

Funeral Director

the Maryland a or 28a-f ahow be notified at WITH "natural", or items 23s death

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturat", or the any injury or other traumatic avant, the Medical Exerciting

Baltimore, Maryland 21215-0020

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. signed by the a P.O. Records, been sig page 2 s has Division of Vital Physician: this funeral After or Attanding

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30. Name/a

Director Funeral by Completed Be **Physician** /Medical Examine Physician/Medical þ Completed Be Certification: To the

A.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 XM 2 □ F 73 196-14-3286 3, 1926 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6320 Brown Ave 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Status Black, White, etc. 1 ☐ Never Marriad 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Newspaper 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) George Daubert Myrle Light 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Allan Daubert /son 2004 Brunt St Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Date 20c. Location - City or Town, State Oct 8 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 1999 | Baltimore, MD 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses brokon 7110 Sollers Point Rd 5M 23a. Part 1. Enter the disease of complications that caused the death. shock, or heart failure. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Causa (Final disease or condition resulting In death) a Hypertensive Arteriosclerotic Cardiovascular Disease Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes XXNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 3CER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of fnjury 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Whedical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signat 29c. License number O.C.M.E. OCTOBER 7, 1999

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year) 8 OC. 1999

JOHN E.SMIALEK MD.

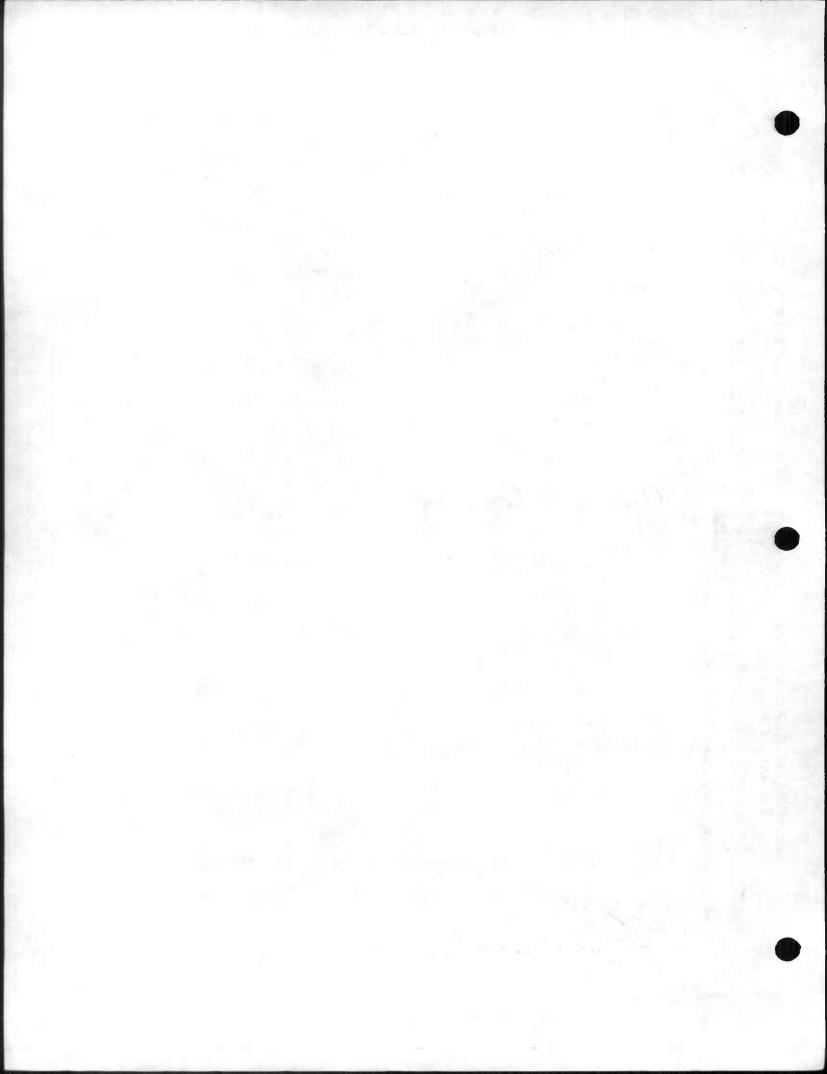
addras

32. Registrar's Signature

of person who completed cause of daath (Item 23a) (Type, Print)

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q AMENDED ITEM 8.10b PER FH G776 10/15/99 AH Certificate of Death t. Decedent's Name (First, Middle, Last) 2. Defe of Death 3. Time of Death Month Dev **Physician** 3:06 RALPH ERWIN. OCTOBER 1999 04 /Medical 4e Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR CENTER BALTIMORE BALTIMORE HOSPITAL If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth 4/22/19199. Birthplace (Stete or Foreign (Month, Day, Year) Virginia

Virginia 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1₩ M 2□ F 214-18-8240 Director Usual Residence of Decedant tob. County ANNE ARUNDEL 10a Sfete 10c. City, Town or Location t 0d. Inside City Limits 28s-f show 1 □ Ves 3 □ No MD Annapolis Jessup Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20794 TICA C-63 Clark Road 'natural', or hama 23a. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedenf Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 11. Merital Status 1 D Yes 2 No If Yes, Give Year or Detes: WWII 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) t5. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Metro Transit Authority Bus Driver 10 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be 12 should be that and Merital His marked of Adrian Louise James O. Erwin 2 permit. Pages 1 and 2 sh, Department of Health and Important. If them 27 is main any injury or 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C-63 Clark Road, Jessup, MD 20794 19a. Informent's Name/Ralationship (Type, Pnnt) C-63 Clark Road, Jessup, MD Viia Lello Erwin - Spouse 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 10/06 Metro Crematory Baltimore, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. a 12 Ridgely Ave. Annapolis, MD 23a. Part1. Enter the disease, or complicefions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erresf, shock, or heart failure. List only ona ceusa on each line. Approximete Intarval Between Onset and Death Physician /Medical Immediate Cause (Final 10 days Seosia diseese or condition resulting in death) Examiner Due to (or es e consequence of): 3 weeks GASTRIC CANCER The law requires that the death certificets be executed Sequantially list conditions, if any, leading to immadiate cause. Entar Underlying Ceuse (Disease or Injury that initieted avants resulting in daath) Last Due to (or as e consequence of). physician Box 68760 Physician/Medical the Due to (or as e consequence of): P.O. F signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ■ Yes 2 No 3 Probably 4 Unknown DISEASE. CORONARY ARTERY Records, þ 24b. Were autopsy findings aveilable prior fo completion of cause of deeth? Completed 24a. Wes en autopsy DIABETES MELLITUS t ☐ Yes 2 No certificate t ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

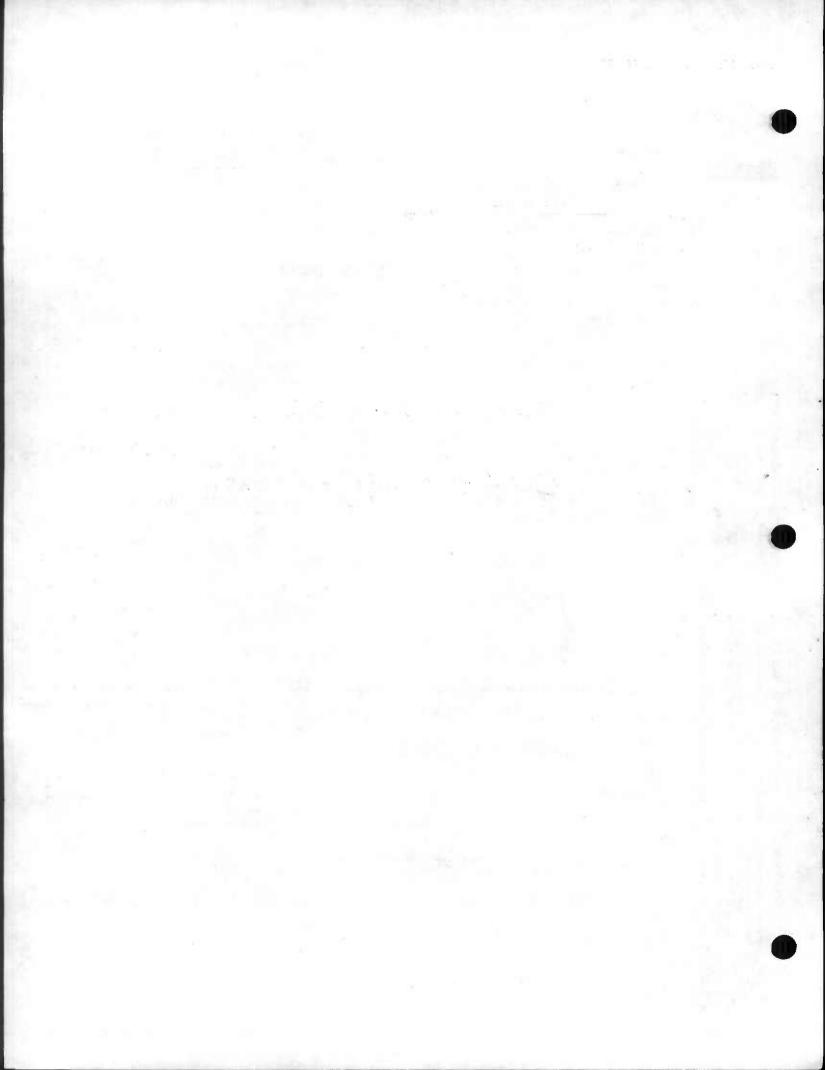
To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1

Inpetiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No Certification: To 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1) Netural 1 Tas 2 No 2 Accident 3 Suicide 6 Could not be datarmined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide t⊠ Certifying Physician: To tha best of my knowledge, death occurred et the tima, data and place, and dua to the causa(s) and manner as stated.

2☐ Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daeth occurred et the time, date end place, end due to the causa(s) and manner steted. edical 29a. Certifiar 29d. Date signed (Month, Dey, Year) 29b. Signature end fitle of certifier 29c. License number PGY2 hileant 13132 OCTOBER 04,1999 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print) RAMIACHANDRUNI HARBOR HOSPITAL CENTER SRIKANTH 31. Defe filed (Month, Day, Year) 32. Regisfrer's Signeture State Registrar

DHMH 16 Rev 6/95

OCT 8 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month TERRELL FISHER DAVOR 12:40 m 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 24 Hrs. 8 Date of Birth Hours Min. (Month, Dev. Year) 6. Sex 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months None Yrs. Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No SUITLAND PRINCE GEORGES 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2524 WHITE HALL ST. 20146 U.S.A 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Race - American Indien, 11. Merital Stetus Black White etc. 1 Never Merried 2 Married 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Yes 2 No Specity Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) NONE - INFANT NONE - INFANT NONE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) PATRICE JACKSON LOUISA FISHER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) PRINCE GEORGES HOSP. CTR. 3001 HOSPITAL DRIVE CHEVERLY, MOZO185 Dete 20b. Plece of Disposition (Neme of cemeters, crematory or other of 20c Location - City or Town, Stete 20e. Method of Disposition | Burial 2 | Cremation 3 | Removel from State 22. Name end Address of Fecility , or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory ture. List only one cause on each line. Immediate Cause (Final diseese or condition resulting in deeth) PREMATURE Due to (or es e consequence of) EMNATAL INFECTION Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy tindings eveilable prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 2 12 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

the

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certificate

Hospital or Attending Physicien: 24 hours after deeth. Funeral Director: After this certificately filled in by the funeral director,

To the Funeral Dir.

To the

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Completed

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Certification:

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Physician

/Medical

Examiner

Director

Funeral

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7 is merked other than "natural", or items 23a or 28a-f eho traumstic event, tra Magical Examinar must be inclified at

"natural", or

permit. Peges 1 end 2 should be filed withir Department of Health and Mental Hygiene Important: If Item 27 is merked other than any Injury or other traumatic event. In

aitimore, Maryland 21215-0020

Box 68760

P.O. F

Records,

Division of Vital

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Lest Physician/Medical

4 Homicide

29b. Signeture and title of certifier

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1958 1771 1 Yes 2 No 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28c. Injury et Work?

27. Manner of Death 1 Pinetural 28a. Dete of Injury (Month, Dey Year) 28b. Time of 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined

1 Yes 2 No 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

DCT 08

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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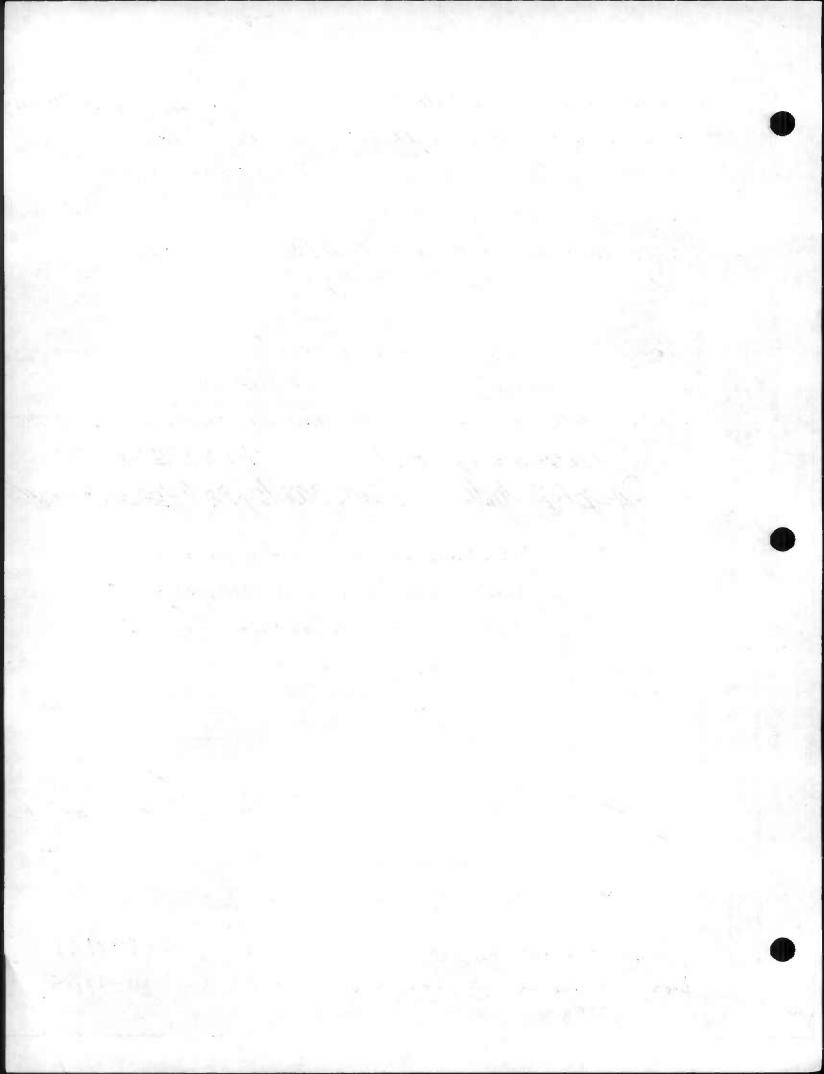
and address of person who completed cause of deeth (Item 23a) (Type, Print)

3001 HOSPITAL Date liled (Month, Dey, Year) Ms.

32. Régistrar's Signature

DRIVE, CHEVERLY,

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DENNIS FOWLER 03 WILLIAM 10 1999 0120 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL UNIVERSITY OF MARYLAND BALTIMORE CITY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 10 M 20 F 95 218-01-0631 July 8, 1904 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita n/a Baltimore Yes 2□ No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 2501 Riggs Avenue 21216 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No 1 Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Elementery/Secondary (0-12) College (1-4or 5+) the Army Warehouseman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis Fowler Rosa Smith 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Alverta A. Fowler 2501 Riggs Avenue Baltimore, Md. 21216 Date 7 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State cemetery, cremetory or other place) NBurial 2 Cremetion 3 Remova from State 4 Donation 5 Other (Specify) Md. National Memorial Park Laurel, Md. 22. Name and Address of Facility Nutter Funeral Homes, 21. Signature of Funeral Service Line 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Per 1. Enter the disease, or complications that caused in death shock, or heart tailure. List only one cause on each light Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 20 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

Examiner Box 68760, that the death certificate be Records, P.O. 2 **Dage 2** certificate Division of Vital 5 Nosphal or Attending 24 hours after death. Funeral Director: After

Physician

/Medical

Examiner

Md.

Director

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Pages 1 and 2 should be fill ment of Health and Mental H ant; if Nem 27 is marked off lary or other traumatic even

Physician /Medical

Examiner

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

29a. Certifier

edical

State Registrar

Physician/Medical ğ Completed Be Certification: To

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Dealt 1 Natural 2 Accident

3 Suicide 6 Could not be 4 ☐ Homicide

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

St, Baltimore, M

28f. Location (Street and Number or Rural Route Number, City or Town, Stele) IECertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature end title of cartifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

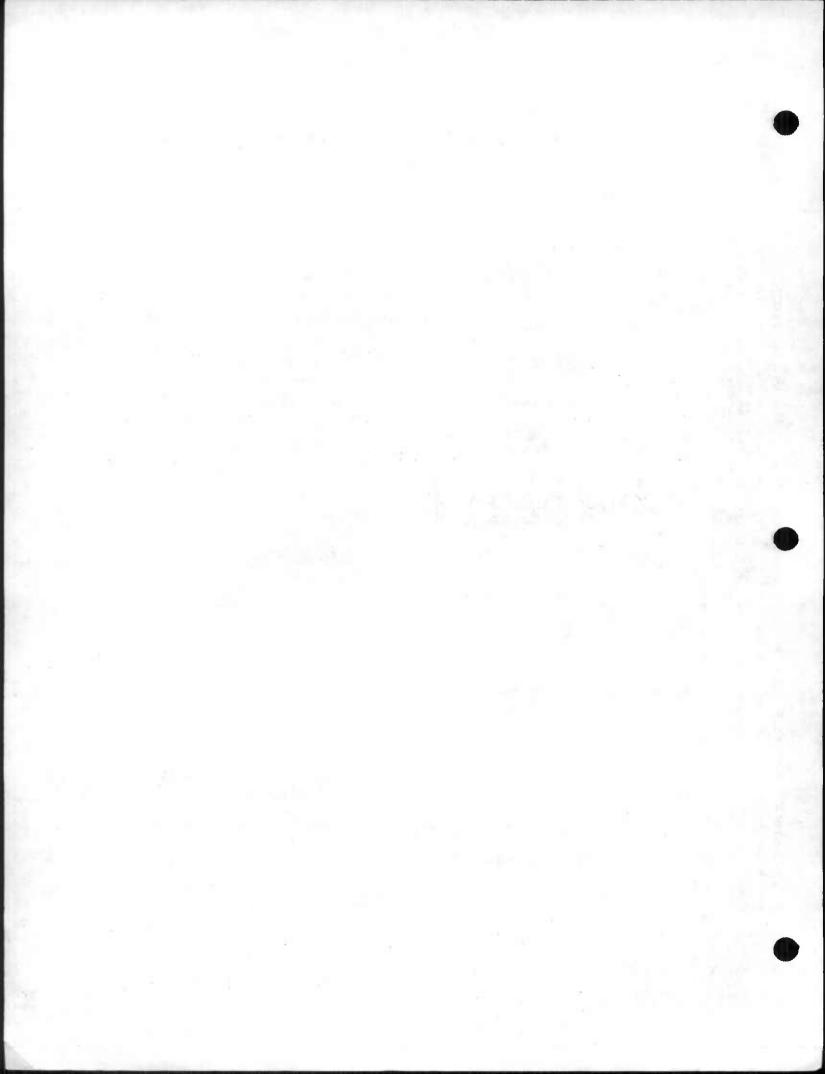
31. Date filed (Month, Day, Year)

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32. Registrar's Signature

DHMH 16 Rev 6/95

within 2 å



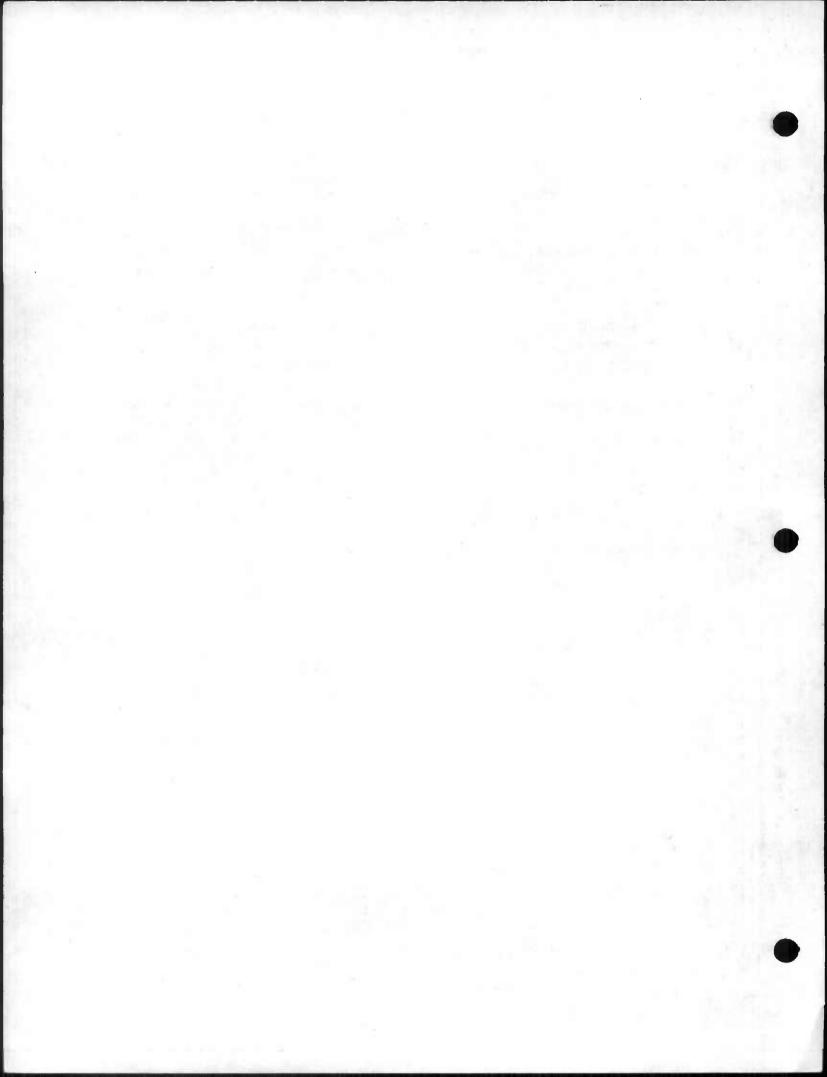
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State of Maryland / Department of Health and Mental Hygiene 99 31553

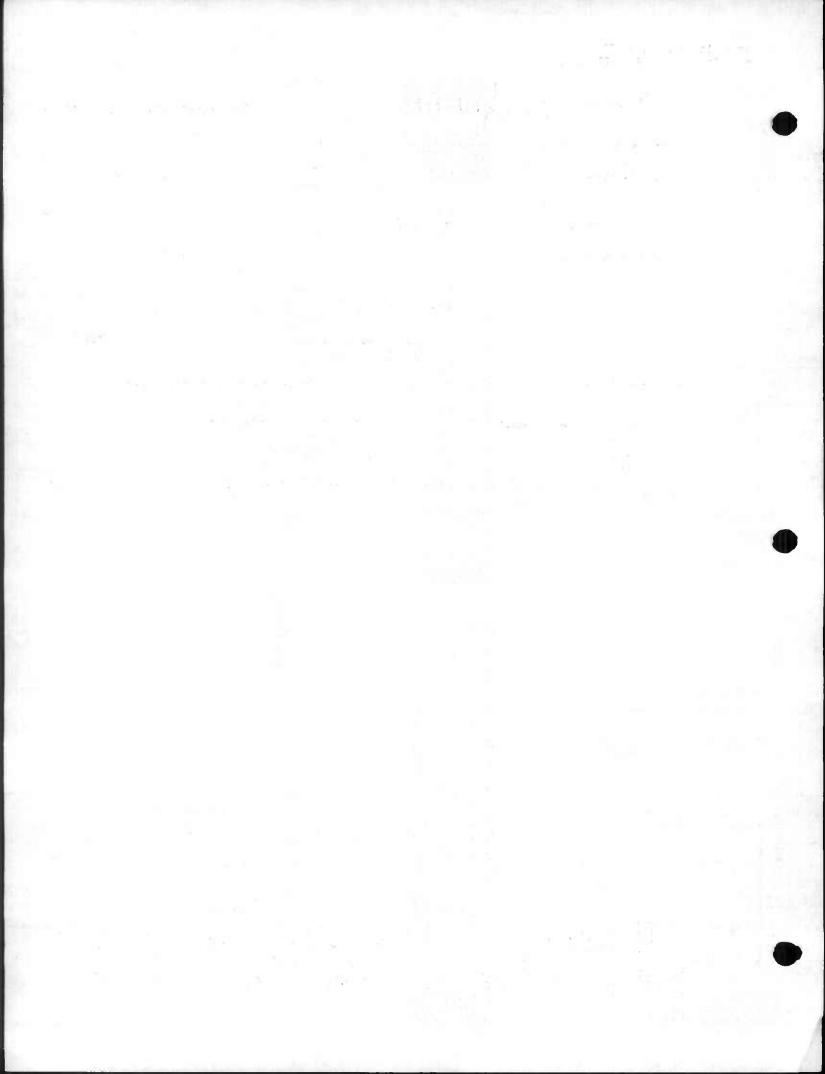
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Funeral Director		5. Social Security P	lumber 6.		7. Age (In yrs. 39	last birthday) Yrs.	ff Under Months	1 Year Days	If Under 24 H Hours M				9. Birthple Country	oce (State or Foreign MD				
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72 hours	et e	(Spe	15. Decedent's E	ducation	16a. Dece	dent's Usua kind of wo	d Occup	pation during most of w	working	16b. K	(ind of Bu	isiness/Indu	istry					
Naryland 21215-0020 2 should be filed within 72 hours af and Mental hygiene. Is marked other than "natural", or sumatic event, the Medical Exam	Completed	Elementery/Secondary (0-12 Unknown		College (1-NA	4or 5+)		orer	se retire	during most of w d)	, on any	v	ario	ous t	trades				
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0 00			position Cremetion 3 [5 Other (Speci			Place of Dispo cemetery, cres	matory or of	ther pla	ce) st VA	Cem. 10				m, Stete MD.				
Baitime pemit. Pag Department Important: If any Injury o		21. Signeture of I			0					altimor		-						
Physician /Medical Examiner	Je.	23a Pert1. Enter shock, or her Immediate Cause disease or condition resulting in death)	(Finel	· F	ally	or es a consec	quence of):						1	Infervel Between Onset end Deeth				
OX 68760, n certificate be executed anding physician and use as the burial-transit	/Medical Examiner	edical	Sequentially list or if any, leading to in cause. Enter Undo Cause (Disease or that initioled event resulting in death)		c		or as a consec or es a consec											
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C & § 5	Certification:	27. Manner of Deal 1 Natural 2 Accident 3 Suicide	5 Pending investigation 6 Could not be	NA		28b. Time o Injury	М	ry at rk? ∣Yes 2 □ No	28d. Describe									
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To the Hospital or I within 24 hours effect to the Funeral Director Completely filled in Exercise 10 to 10 t	edicai	29a. Certifier (Check only one)	1☐ Certifying Pt 2☑ Medical Exa	hysician: To the b miner: On the bas and marine	is of examina													
withi To th	Σ	29b. Signature and	title of certifier	1191			29c	. Licen:	se number		29d. Da	ate signed	d (Month, D	ay, Year)				
JXI		,	{	1/ W				0.0	C.M.E.		OCT	OBER	3,199	99				
U	M	30. Name and add	ess of person who	completed cause	of death (Item	n 23a) (Type,		Penr	Street	, Baltim	ore,	Mary	yland	21201				
Sta	ate	31. Dete filed (Mon	th. Day, Year)	32. Re	gistrar's Signe	atyte A	Jan 16	1										

DHMH 16 Ray 6/95



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Amended Items 16a,16b,G776perAB,dhb State of Maryland / Department of Health and Mental Hygiene Q Amended Item 5, Per Fam/G776 10/19/99dhb Certificate of Death 1. Decedent's Neme (First, Middle, Last 2. Date of Deeth 3. Tima of Death Month **Physician** Von September 13, 1999 8:00 pm /Medical 4e. Fecility Neme (If not institution, give street end number 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 90 Sunrise Drive Rising Sun 5. Social Security Number 235-58-5262 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1₽M 2□F Months Deys Hours Yrs. Director 235-58-5489 Usuel Residence of Decedent 60 Jan. 4, 1939 W.VA. with the Mandend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits would treumetic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No 28a-f MD Ceci1 Rising Sun 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23a 90 Sunrise Drive U.S.A. 21911 death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after d Department of Heelth and Mentel thyglene. Important: if frem 27 is marked other than "naturel", or frem any injury or other treumetic event, the Medical Francisco Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Married 1 Yes 2 No if Yes, Give Year or Detes: 2/55-74 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired)
Chief Petty Officer
Naval Officer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Navy Elementery/Secondery (0-12) Arms Forces College (1-4or 5+) 12 0 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumeme) Matthew Graham Narcissus Erma McKinney 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Loretta M. Graham/spouse 90 Sunrise Drive, Rising Sun, MD 21911 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 X Donetion 5 ☐ Other (Specify) Made, Director State Anatomy Board, 655 W. Baltimore Street, 21. Signature of Funeral Service Licenses Š Ronald Mille ~ Baltimore, MD 21201 23a. Pen1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each lina. Approximete interval Between Onset end Deeth **Physician** /Medical immediata Cause (Fine) diseese or condition resulting in death) Examiner to (ones a consequence of). Examiner the death certificate be executed Sequentially list conditions, if any, laeding to Immediate cause. Enter Underlying Ceuse (Disaese or Injury thet initieted events resulting in deeth) Lest (or es e consequence of): physician a s the buriel-i 0 Box 68760. Physician/Medicai guence of); ettending (ed by the deteched Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert i. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 3 □ Probably 4 Donknown 1 ☐ Yes 2 ☐ No The lew requires that δ should I 24b Were autopsy findings evallable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed page 2 certificate 1 Yes 20 MG or Attending Physician: Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Othar: 4 Nursing Home Certification: To 1 Yes 2000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Hauidence 6 □Other (Specify) this funeral Manner of Death 28e. Dete of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Natural 5 Pending after death. 1 Tyes 2 □ No 2 Accident 3 Sulcide 6 Could not be 28a. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 Homicide .5 filled 24 hours a 29e. Certifier edicai Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end manner es stated. completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stetad. (Check only one) a within 2 To the 29b. Slgnarur 29d. Dete signed // 23a) (Type, Print) ceuse of daeth (item. 32. Registrar's Signeture State 8 1999 0 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death September 20,1999 5:20AM **Physician** Sylvia Garberg /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey Year) 913 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1□ M 2□ F 86 Wisconsin 389-03-9650 Yrs. Director Usual Residence of Decedent the Maryland Apple 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow with injury or other traumatic avent, the Medical Examples must be notified at once. Yes 2□No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 10714 Potomac Tennis La. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify þ 3℃Widowed 4 Divorced Yeer or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Gollusch Gussie Siegel 0 19e. fnformant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Barman/Daughter 10833 Willow Run Ct Potomac, MD. 20910 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, cremetory or other place 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Norbeck Memorial Olney, MD. 9/23 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Takoma Funeral Home. ugh 254 Carroll Ave. NW Washington, 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate fntervel Between Onset and Death **Physician** Myocardial Infarction /Medical Immediate Cause (Finel disease or condition resulting in death) Seconds Examiner Ortherosclerotic Vascular Disease Years Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting In death) Last Due to (or as a consequence of) physician s the burial of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 88 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Disease þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? should page 2 s hes 1 ☐ Yes 2 DNo certificate 1 ☐ Yes 2 ☐ No. or Attending Physician: 25. Was cese referred to medicel examiner? Medicai Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Magner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Division 5 Pending investigation after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated. 29e. Certifie completely (Check only one) within 2 To the \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0

State Registrar (Mgnth 999 Year) 32. Aggistrar's Stynature

Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Dr. Michael Grady, MD. 4910 M

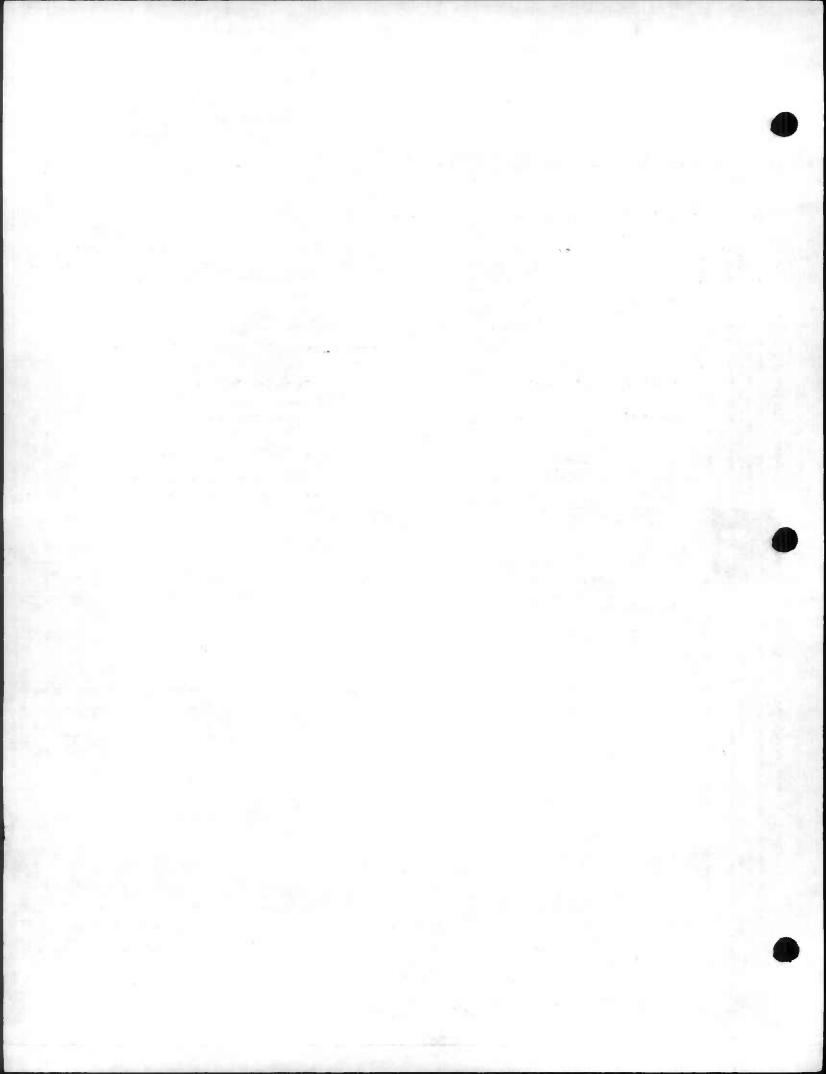
Synature Sparks

DHMH 16 Rev 6/95

D00038781

4910 Mass. Ave. NW. Washington, DC.

September 23, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) D21,1999 Sept. 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. O Month, Par. Year 9 1 3 5. Social Security Number 117-01-2826 9. Birthplace (State or Foreign NEW) York 1⊠M 2□F Usual Rasidence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6121 Montrose Rd. United States 12. Was Decedent Ever in U,S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Maritai Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 HWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elemantary/Secondary (0-12) Department of Defense US Government 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Max Green Mary Krichefsky 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. informant's Name/Ralationship (Type, Print) Alan Green/Son 14 Prospect Ave. Ossining, NY. 10562 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Neme of 20c. Location - City or Town, State King David Memorial 9/23 Falls Church, VA. 4 ☐ Donation 5 ☐ Other (Specify) Stein Hebrew Memorial FH. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility 254 Carroll Ave. NW Washington, DC.20012 aused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Interval Between Onset end Deeth ASPIRATION PNEUMONIA, LOWER COBES I WEEK Immediata Causa (Final disease or condition rasulting In death) Sequentially list conditions, if any, laading to Immediate ceuse. Enter Underlying Cause (Disaase or Injury that Initiated evants resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) Part if. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? DEMENTIA, VASCULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings evailable prior to 24a. Was en autopsy performed? completion of ceuse of death? 2X No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicei examiner? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 3 ☐ Sulcide

Physician /Medical Examiner

Physician /Medical

Examiner

Directo

Funerai

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Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at

the Maryland

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physician and the burief-transit 88 esn signed I i certificate hes birector, page 2 s

requires that the death certificate be execu

or Attending Physician:

Hospital

To the Within 2

Aftar

Division of Vital Records, P.O. Box 68760,

Examiner funeral 24 hours after death.

Physician/Medical Be Lo

þ Completed Certification:

Medicai

4 D Homicide 29a. Cartifiar (Check only one)

6 Could not be datarmined

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

nTrose RD Rockville MD2 0857

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ourtiller

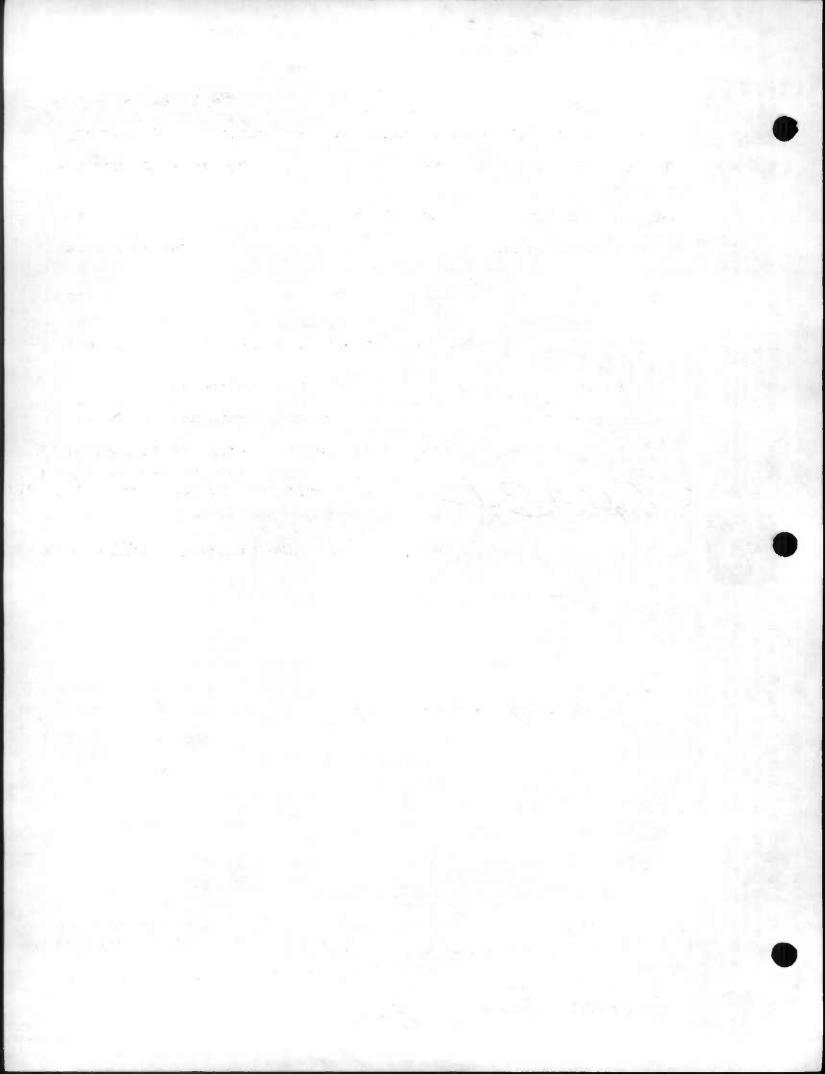
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print) 6121

M.D. 31. Date filed (Month, Day, Yeer) OCT 0 8 1999 32. Registrer's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Woodrow Wilson Gentry September 30,1999 2:43 AM 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Ctr. Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1☑ M 2□ F 226-09-9900 87 May 7,1912 Virginia Usuel Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Dundalk Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21222 111 Patapsco Avenue United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 HWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Steel Industry 8 years Chipper 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Tobias Gentry Cora B. Connelly 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald W. Gentry/Son 1405 Loch Carron Way Bel Air, Maryland 21015 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Dother (Specify) Oak Lawn Cemetery 10/4/99 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 2 7 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth NEW PROTECT OF MEDICAL SERVICES Immediate Cause (Finel disease or condition resulting in death) two weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhileted events resulting in death) Last MOTOR VEHICLE ACCIDENT Due to (or as a consequence of):

Physician /Medical Examiner

and

physician

The law requires that the death certificate be executed

or Attending Physician: this

Division of Vital Records, P.O. Box 68760

Department of important: If any injury or phose.

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after nater theatilth and Mental Hyglens.
net: If flam 27 is marked other than "natural; or flam ury or other traumatts avant, the Mental Lamina

Baltimore, Maryland 21215-0020

Director

Funerai

Be Completed by

death with the Maryland

Examiner the burial-transit ician/Medicai 9 USB To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Pulmonary Disease	1 Yes 2 No	3 Probably 4 Unknow
	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
26. Place of Deat	th (Check only one)	
oital: 1 Dinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other	er (Specify)
28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? SEPTEMBER LATA 1 30 M 1 Yes 25 No	28d. Describe how injury occurr PEDESTRIAN STYLLIN	
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 9 DUNGAIK AVE	28f. Location (Street and Numb City or Town, State)	er or Aural Route Number,
21	26. Place of Deat ital: 1 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho 8a. Date of Injury 28b. Tima of Injury 30 M 1 Year) EPTEMBER 1 PAP 1 30 M 1 Yes 2 No 8e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	24a. Was an autopsy performed? 1

State Registrar

29b. Signature and title of certifie

EUANS , MD 31. Date filed (Month, Day, Year) OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Hodeins Source Moderal Cester 4940 Eastern Age 32. Registrar's Signature

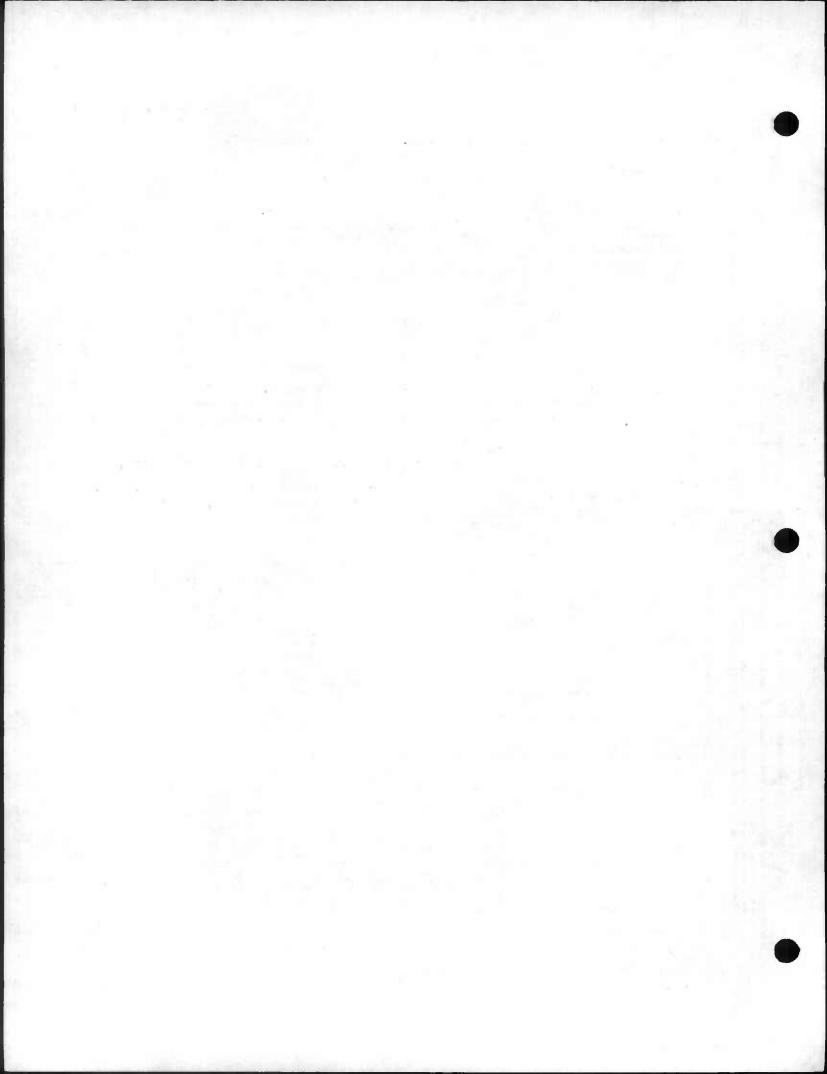
29c. License number

29d. Date signed (Month, Day, Year)

BALTIMONE MO 21224

OCTOBEY2

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 716 EDNA GRYKEN OCTOBER 1999 7 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore. N/A If Under 1 Yeer 5. Sociel Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 X F 129-05-1234 Yrs. Maryland 83 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Maruland Baltimore. Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1000 Franklin Ave., Apt. 307 21221 U.S.A. Harns 23s 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural, or iten any Injury or other treumatic event, the Medical Examina-Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 8th Grade 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Joseph Crouse Anna Winter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Sigmund Gryken (husband) 1000 Franklin Ave., Apt. 307, Baltimore, MD 21221 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremete 3 Removel from State 4 ☐ Ponetion 5 ☐ Other (Specify) Most Holy Redeemer Cem. 10/6/99 Baltimore, Maryland 21. Signature of Federal Service Licensee

22. Name end Address of Fecility
Schimunek Funeral Home, Inc.
9705 Belair Rd., Baltimore, MD

23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical 1-2 days oneumonia Examiner Due to (or es e consequence of): Examiner mexically resistant 5 aureus cellelitis. week physician and the bunal-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest 1-2 months Box 68760. decubit Physician/Medical Due to (or es e consequence of) left himeranisis USB P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? hydrocephalus malautution 1 Yes 2 No 1 ☐ Yes 2 ☐ No. of Vital 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospitel: 1X Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28d. Describe how injury occurred 28c. Injury et Work? Division After 1 Naturel
2 Accident Attending 5 Pending investigation n 24 hours after death.

He Funeral Director: After pletely filled in by the fun 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ò Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/02 DO852243 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BAYMEN CARLE

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dev. Year)
OCT 8 19

1999

5505 HODKINS

A2. Registrar's Signetur

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Milledge Golphin october 06 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOSPITAL Baltimore n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 249-07-6218 Yrs Director Nov. 28, 1917 SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Director Md. 289-1 n/a Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23s or 3016 Oakley Avenue 21215 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Grade Clergyman Church 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 2 should be 1 and Mental P Luther Golphin unknown 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If Nem 27 is Patricia Golphin wife 3016 Oakley Avenue Baltimore, Md. 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removat from State 4 Donation 5 Stather (Specify) Entombment Woodlawn Cemetery Oct. 12 Baltimore, Md. 22. Name end Address of Facility Nutter Funeral Homes, Inc. 21. Signeture of Funerel Servica Licenses 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) 0 days Gastrointestinal Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Infarction, Renal Failure Be Completed by 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy performed? completion of cause of death? 2 X No 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation e Hospital or Attending 124 hours after death. p. Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) itely filled in by 4 Homicide 29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Within 2 ş

DHMH 16 Rev 6/95

Jolphin, Milledge

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:

> State Registrar

AVI 31. Dete filed (Month, Dey, Year)

OCT

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29b. Signeture end title of certifie

32. Registrar's Signeture

who completed cause of death (ttem 23a) (Type, Print)

HOSPITAL

29c. License number

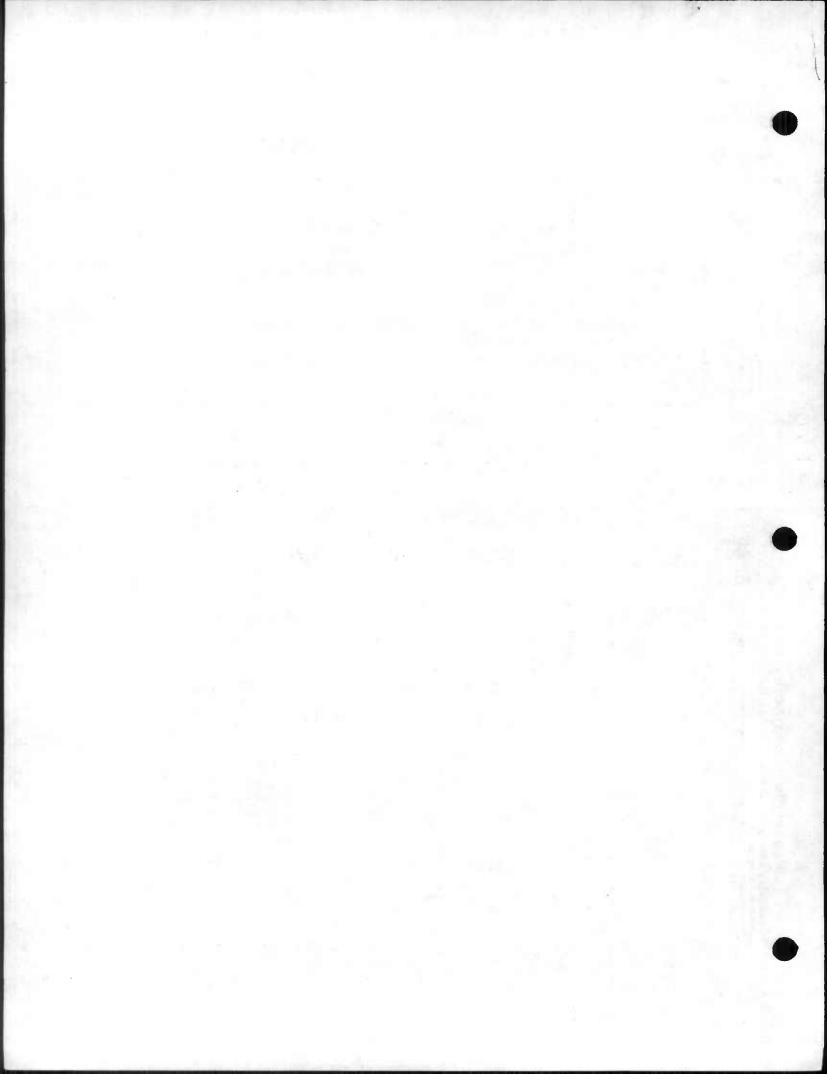
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29d. Dete signed (Month, Day, Year)

W. Belvedere Ave Baltimore, MD

October 06, 1999

SINAI



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 3, 10:52 p.m. THOMAS D. GALE /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston General Hospital Fallston Harkord 8. Date of Birth (Month, Day, Year) 16. 1928 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☑ M 2 □ F Yes 216-20-2549 70 Director Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow rail, or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 298 I Canterbury Road 21014 U.S.A. Funeral death 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if itam 27 Ia marked other than "natural", or itan any Injury or other traumatic event, the Medical Examinations. Armed Porces;
10 Yes 2 No
If Yes, Give
Yeer or Detes: Korea 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bar/Restaurant 8th grade Proprietor 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Alex Golembiewski 0 Stella Miller 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 298 I Canterbury Road, Virginia M. Gale (Wife) Bel Air. MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1

Buriel 2 □ Cremetion 3 □ Removel from Stete Harford Memorial Gardens 10/7/99 4 ☐ Donetion 5 ☐ Other (Specify) Aberdeen. Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road. Bel Air. MD 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Causa (Final ACUTE MYOCARDIAL INFARCTION Minutes disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner CORONARY ARTERY DISEASE Years sician and bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the burial Box 68760, DIABETES MELLITUS TYPE Years Due to (or es e consequence of): P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☑ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Peripheral Vascular Disease ò Records. ate has been signed page 2 should be Be Completed 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? completion of cause of death? certificate 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 1 ☐ Inpatient 2 【X ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending Investigation 1 X Neturel within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) (Check only one) To the 29b. Signeture and the of cartifier 29c. License number 29d. Date signed (Month, Day, Year) D0053536 October 6. 1999 30. Neme and eddress of person who completed cause of death (Nem 200) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Daniel Goldsmith,

8 1999

31. Dete filed (Month, Dey, Year)

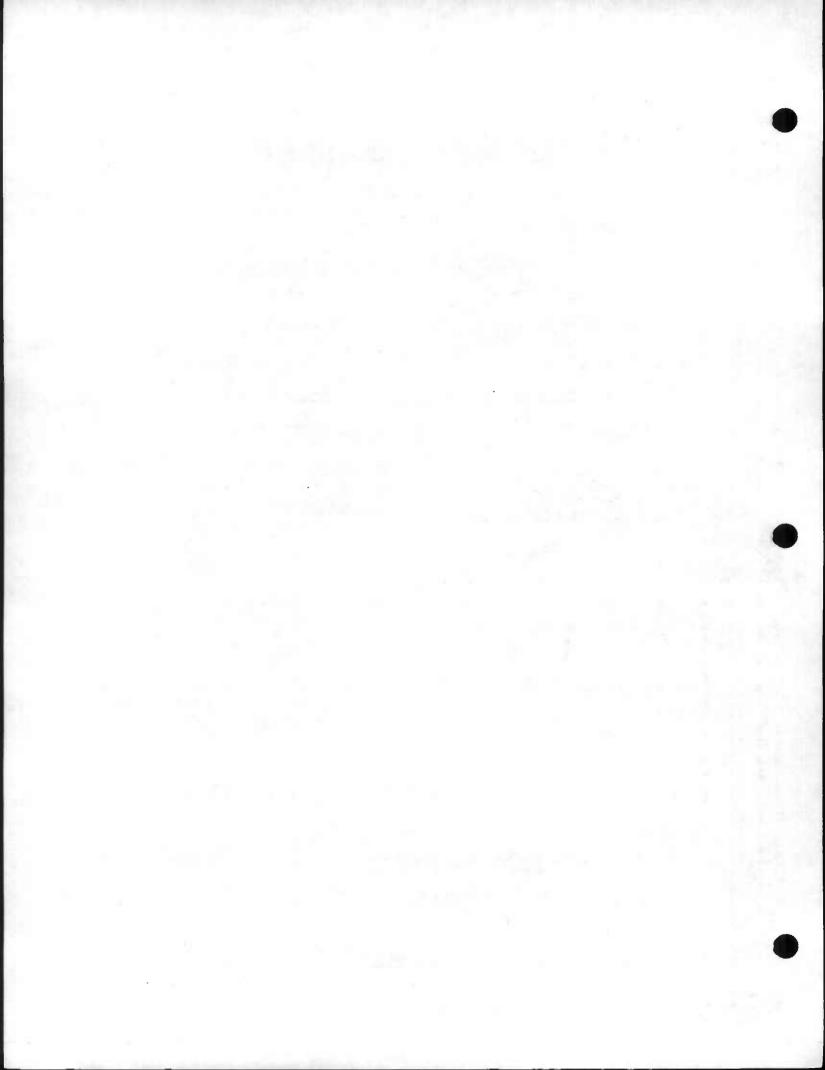
OCT

M.D.

32. Registrer's Signature

1321 Riverside Parkway,

Belcamp. MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) **Physician** Ronald H. Getz OCT 04 1999 11:25pm/Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Steta or Foreign Country) **Funeral** 1 → M 2 □ F Months Days Yrs. 215-46-5782 52 FEB 24, 1947 Director Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other treumstic event, the Madical Examinar must be notified at 1 Yas 2 No Director MD Baltimore Baltimore 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Numbe 132 N. Bradford Street 21224 USA Funeral should be filed within 72 hours after death nd Mental Hygiana. merked other than "natural", or items 23. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ∑ No If Yas, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Biack, White, atc. 1 □ Nevar Married 2 □ Married 1 Yas X No Specify: Specify: White à 3 ☐ Widowed 4 € Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highast grade completed) Elemantary/Secondary (0-12) Cotlege (1-4or 5+) Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Getz Virginia Beachman 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Intormant's Name/Ralationship (Type, Print) Candy Ross/daughter 16320 Sawmill Rd. Stewartstown, PA 17363 Department of Health Important: If item 27 20b. Placa of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State any injury or Baltimore, MD Metro Crematory, Inc. 10/06/99 4 □ Donation 5 □ Other (Specify) neral Service Lices 22. Nama and Address of Facility Thomas Gregor Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter tha disaasa, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, Approximata Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) neumonia) Examiner Due to (or as a consequenca ot): Examiner tiple Myeloma physician and the bunal-transit Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): usa 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause ot death? 24a. Was an autopsy performed? Completed 1□ Yas 20 No 25. Was case reterred to medical examiner? Be 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this 27. Mannar ot Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Panding 1 ☐ Yes 2 ☐ No invastigation 2 Accident hours after death 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, tarm, street, tactory, offica building, atc. (Spacify) 4 Homtcida 24 hours 29a. Certifier (Check only one) Medical 1/2 Certifying Physician: To the best of my knowladge, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. To the Hosport To the Fund Formpletaly fi 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the causa(s) and manner stated.

State Registrar

DHMH 16 Rev 6/95

31. Date tiled (Month, Dey, Yaar)

29b. Signature and title of certifian

JUMMNOY, 32. Registrar's Signature

M.D.

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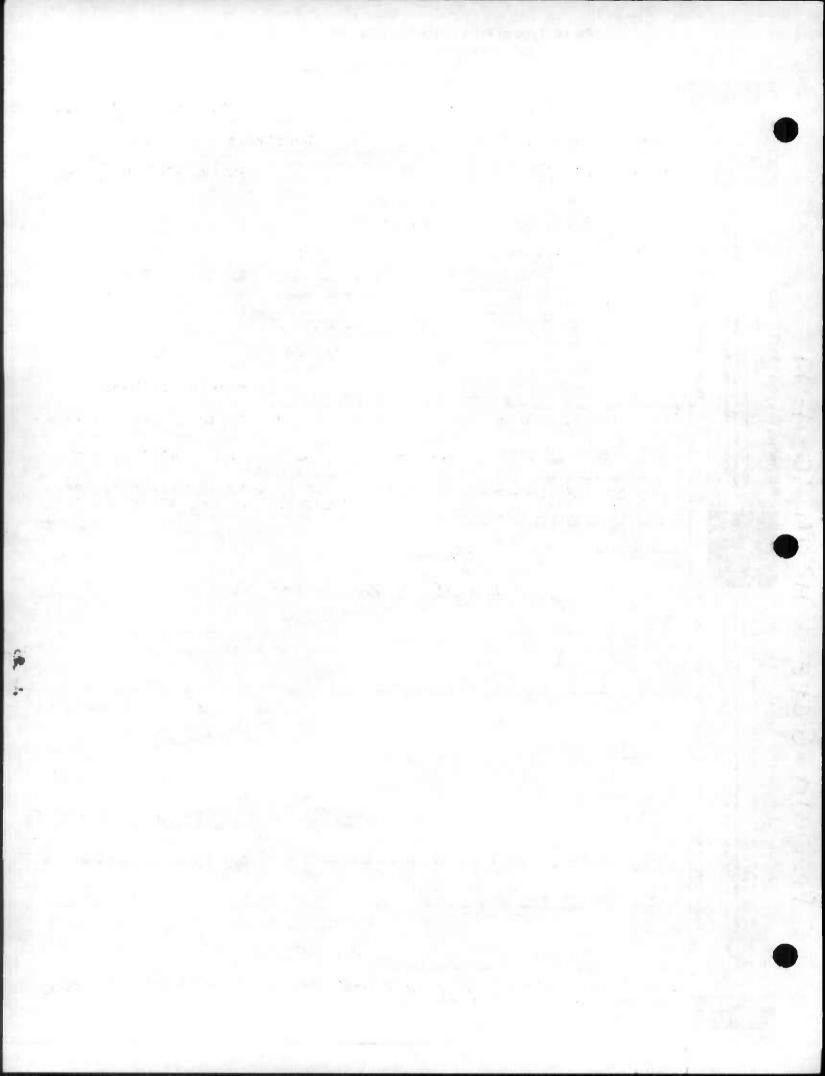
30. Name and address of person who completed cause ot death (Item 23a) (Type, Print)

29c. License number

; 220 TUNBRIDGE POND, BALTIMORE, MD. 2/2/2

29d. Date signed (Month, Dey, Year)

Oct. 5, 1999



Baltimore, Maryland 21215-0020

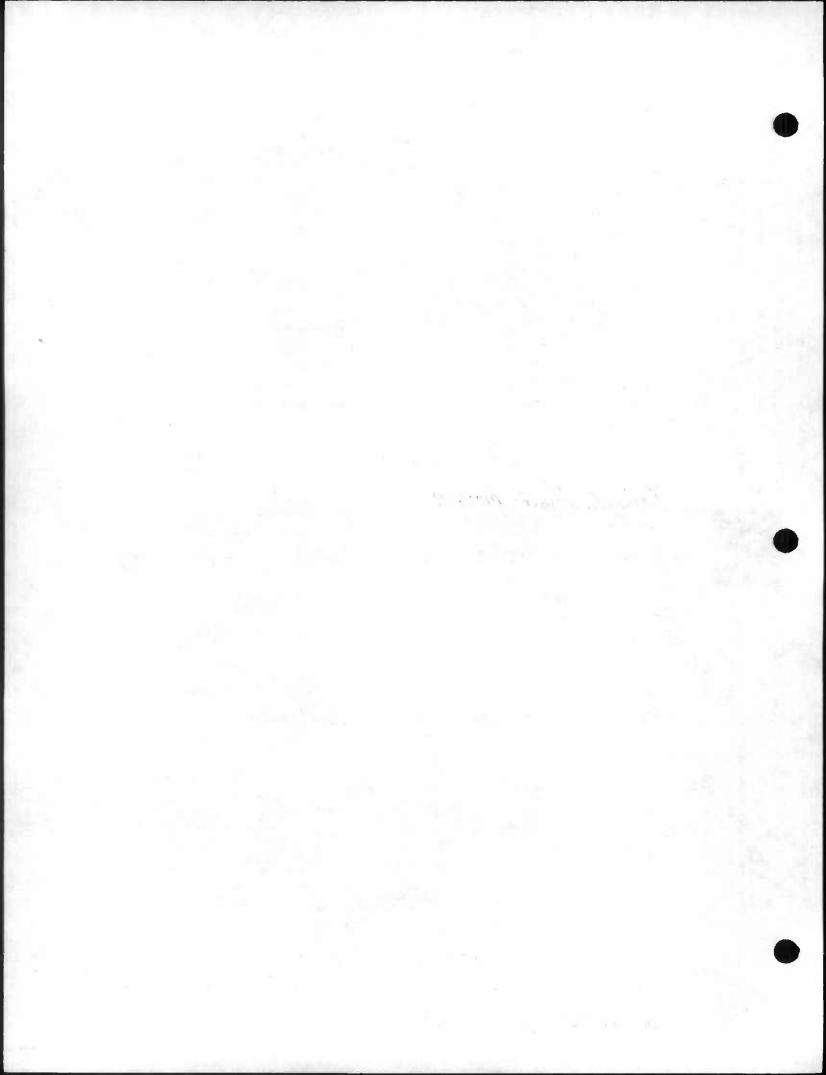
Division of Vital Records, P.O. Box 68760,

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To Be (17. Father's Neme (18. Mother's Name Mae Dez				e (First, Middle, Maiden Sumeme) ZELL						
= =	19e. fnforment's Na	me/Reletionship	(Type, Print)		19b. Mailir	ng Address (S	treet	end Number or Ru	ral Route Num	ber, City or	Town, Stete, 2	ip Code)	
1	Barbara	Hildito	h – wife		228	Collir	าร	Ave., Bal	ltimore	, Md.	21229		
important; if from 27 is marked other than institution, any Injury or other traumetic event, the Medical Earl Bodge. To Be Completed by	20e. Method of Disposition 1									20c. Loc	ation - City or Laurel		
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ation:	27. Manner of Death 1 Netural 2 Accident	5 Pending Investigeti	(Month	28e. Dete of Injury (Month, Dey Year)			Mod 1	y et rk? Yes 2 □ No	28d. Describe how Injury occurred				
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V	30. Neme end eddre	1 R	Que	in			enn	Street,	Baltim	ore,	Marylan	nd 2120	1_
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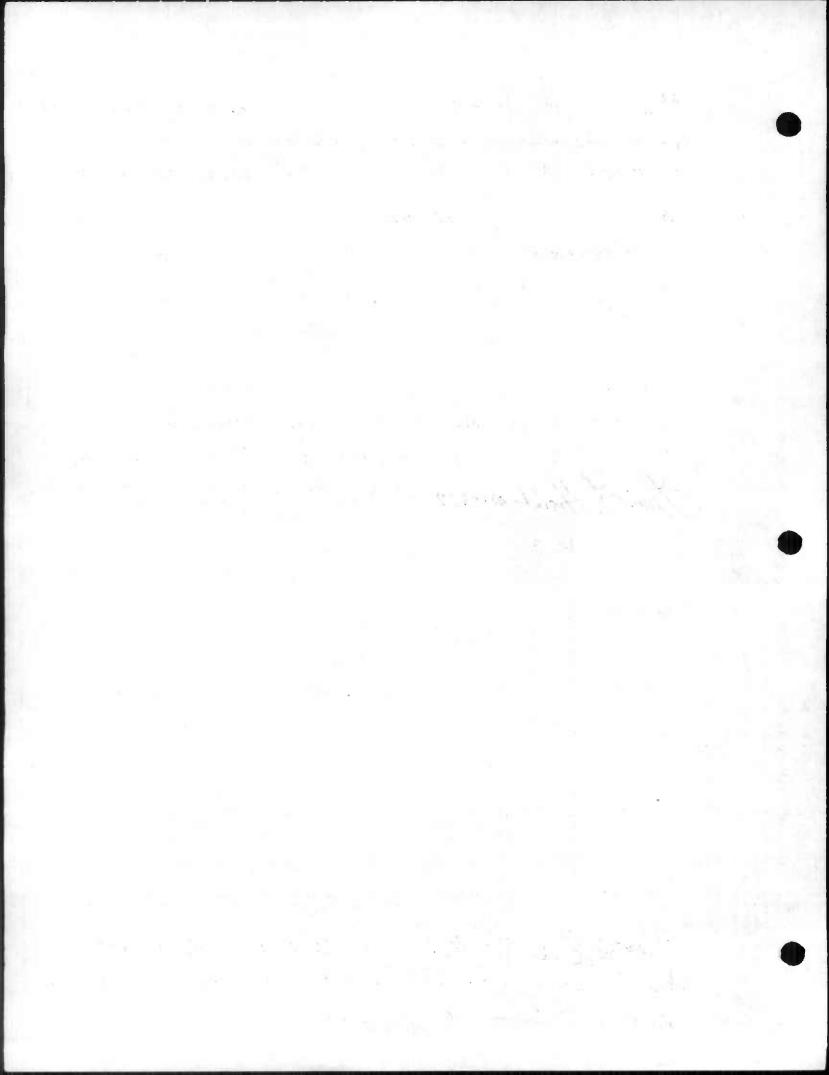
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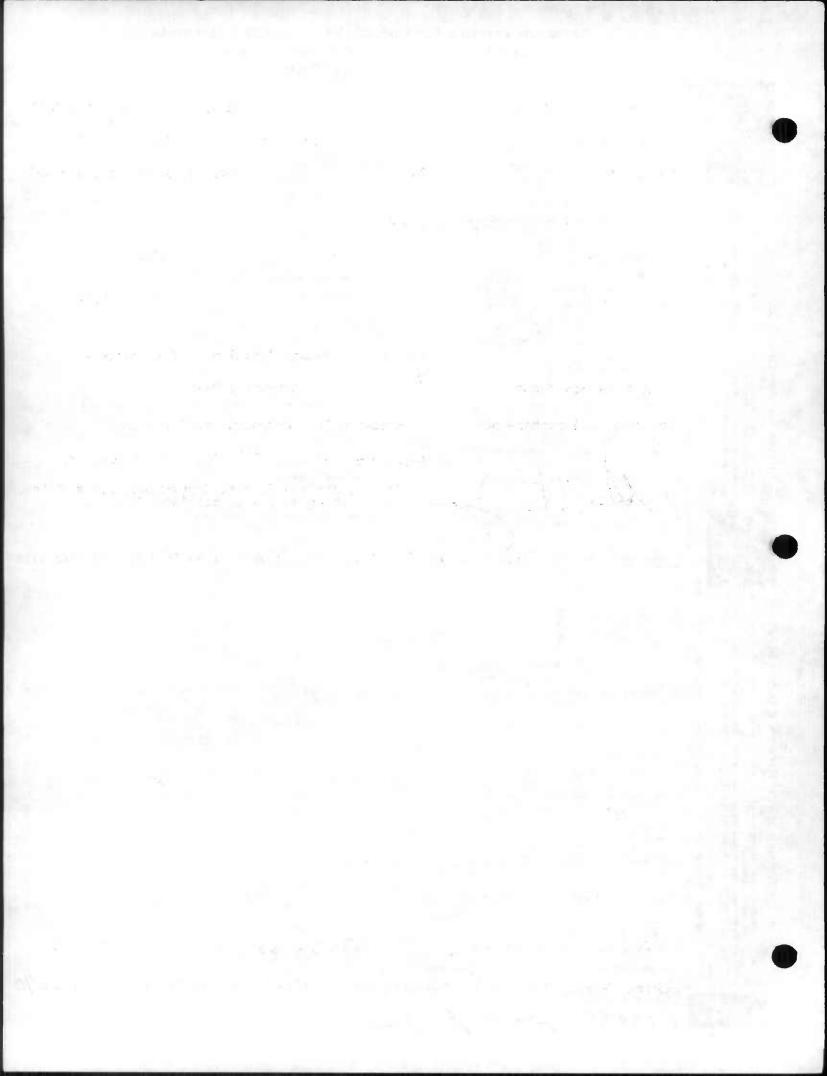
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after death Director: d in by the	Certification:	3 Suicide 6 Could not be determined 28a. Piece of Injury - At building, etc. (Special Countries)	home, farm, s			es 2 □ No 28f. Location (Street end Number or Rural Route Number, City or Town, State)							
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State of Maryland / Department of Health and Mental Hygiene 99 31561.

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Physician /Medical	SUE HIN	SON			OCT.	5, 1999		10:00 AM				
	Examiner	4e Fecility Neme (If not Institution, give	street end number)		4b. City, Town, or L	ocation of Deeth	4c. County of	of Deeth				
		2 Leeds Road			Hanover		Anne					
	Funeral Director	233-10-0093	T++ +67 =	orthday) If Under 1 Year Months Deys		8. Date of Birth (Month, Day, NOV. 15	Yeer) , 1919	9. Birthple Count West	ace (Stete or Foreign hy) t Virginia			
	and s	Usuei Residenca of Decedent 10a. Stete 10b. County	10c. City, Tov	n or Location				10	Od. Inside City Limits			
	vith the Meryti or 28a-f sho be notified a		ndel County Har	10f. Zip Code		1/	1 □ Yes 2					
	s 23s or must be real Dir	2 Leeds Road	10. Was Danadast Firev in H.C.	2107			USA	g. Citizen of Whet Country? USA 14. Race - American Indien,				
020 burs after death with the Merylan et', or items 23s or 28s-f show Exactiner must be notified at	hours after death with the Meryland urel', or items 23s or 28s-f show all Examples must be notified at all by Funeral Director	11. Merital Status 1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 Tyes 2 No If Yes, Give Yeer or Detes:	13. Was Decedent of If Yes, specify Cul		Rican, etc.)		, White, e				
5-0	ed within 72 hours ygjene. ner than "naturel", nt, tre Medical Ena Completed by	15. Decedent's Edi (Specify only highest grad		Decedent's Usuel Occu (Give kind of work done	during most of work	king	16b. Kind of Bus	siness/Ind	ustry			
121	d within 72 piene. r than "nat the Med c	Elementary/Secondery (0-12)	College (1-4or 5+)	`life. DO NOT use retire								
7 5	filed within Hygiene. other than ent, the Me	12 17. Fether's Neme (First, Middle, Last)	Vic	ce Pres F	linson Avi	ation e (First, Middle, N	Transp	ortation				
Maryland 21215-0020	Mental Me	Anthony Sam T			Cather	ine Mayo	вуо					
Mar	2 6 9 6	19a. informant's Neme/Reletionship (T		b. Mailing Address (Stree					Code)			
	Health mm 27 mer tr	Terrance L. Thras		Basswood C		Doto	Md. 21	228 City or Toy	wn. Stete			
Baltimore, permit. Pages 1 as Department of Hea Important: if Ilean any Injury or other other other.		1 Burial 2 Cremetion 3 4 Donetion, 5 Other (Specify	Baltin	of Disposition (Neme of ary, cremetory or other plan nore Nationa 22. Name end Addi	l Cem.	0/12/99	Balti					
	Separation of the control of the con	21. Signature of Fundiral Service Green	e @ Mead	owric	dge MP, Inc.							
_	40240	/Way L	or In	7250 Washi	ngton Blv	d., Elkr	idge, M	d. 2	21075			
П		23a. Part1. Enter the diseese, or comp shock, or heert failure. List only of	ilicetions that caused the deeth. Do one cause on each line.	not enter the mode of dy	ing, such es cerdiec	or respiretory erre	est,		Approximete intervei Between Onset end Deeth			
1	Physician /Medical	Immediate Cause (Fine)										
	Examiner	disease or condition resulting in deeth)	0512	1	DUNITA							
			Due to (or es e	consequenca of):				1				
	executed in end inel-trensit		b					i i				
_6	el-tre	Sequentially list conditions, if eny, leeding to immediate	Due to (or es e	consequenca of):								
68760,	ifficate be executed g physicien end as the buriel-trensit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of):										
89	g physicie es the bur ledical	resulting in deeth) Lest										
Box	nding use c											
	d for	Pert ii. Other significant conditions co	entributing to death but not resulting	23b. Did to	bacco usa con	tribute to	the cause of death?					
P.O.	v requires that the death cert been signed by the ettendin should be deteched for use leted by Physician/M	Total Sura significant conditions of	minouting to death out not resulting	in the directlying seeds g		100	-	bebly 4 ☐ Unknown				
Vital Records,	The law requires the sate has been signe, page 2 should be completed by					24e. Was a perior		eve	ere autopsy findings eileble prior to mpletion of cause			
ec	law nes b e 2 sl							of c	death?			
<u></u>	The la					1 □ Ye	s 2000	1□] Yes 2□ No			
/ita	Physician: The lav this certificate hes rel director, page 2 To Be Comp	25. Wes case referred to medical exeminer?	Hamital.			th (Check only on	е)					
of	hys hys	T Tes ZINO	Hospital: 1 ☐ inpatient 2 ☐ ER/O	utpetient 3 DOA		ome 5 Reside)			
	h. After funer funer	27. Menner of Deeth Natural 5 Pending	28e. Dete of injury (Month, Dey Yeer) 28b.		ork?	28d. Describe ho	w injury occurr	ea				
sio	Attending or death. actor: After by the fune	Accident investigation]Yes 2□No	ORA Location (C)	want and Mumb	oz oz 0	I Doute Number			
Division	PAST TO	4 Homicide determined	28e. Place of injury - At home, f building, etc. (Specify)	arm, street, fectory, offici		 Location (Street end Number or Rurel Route Number, City or Town, State) 						
	Hospital 24 hours Funerel stely filled	29a. Certifier Certifying Phy	rsictan: To the best of my knowledg	e death occurred at the	time, date and place	and due to the co	am bas (s)esus	nner as st	ated			
	he Hospi in 24 hou he Funer pletely fill edical		iner: On the basis of examination a end manner stated.									
	within 2 To the comple	29b. Signature and title of certifie										
	-3-	John St	idua	7838		101	5	99				
	11/1	30. Neme end eddress of person who d	completed cause of death (item 23a)		- 0 - 0							
	Molo	~		PARMI	2 Raso	/ 1 A/7	7+10.11	Ly 1	n 21090			
	State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture	11/1/1/1/1	1 ((()))	C I N	TILUI	///	1.7 2/0/0			
	Registrar	OCT 0 8 1999	General G	parks								
DH	MH 16 Rev 6/95	001	1	pouce								



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Item: 5 per F.H G=777 11/2/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07, 1999 4c. County of Death HARTMAN WILLIAM 0705 AM October 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Memorial BALTIMORE BALTIMORE Hospital union H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 20 1915 5. Social Security Number 235–18–1956 If Undar 1 Yaar 9. Birthplace (State or Foreign Country) West Virginia 6 Sex 7. Age (In yrs. last birthday) 100M 20 F Months Days 83 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 813 Woodrow Ave. 21221 IISA 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 3€ No Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Mechanic Beth Steel 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Seymor L. HArtman MArtha Seabolt 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Md. 21221 George Dorbert/brother-in-law 6 Avemal Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removal from State 10/11/99 Holly Hill Cemetery Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part I. Enter the disease, or complications that caused the death D shock, or heart failure. List only one cause on each line. 300 MACE Ave. Baltimore Md. 21221 enter the mode of dying, such as cardiac or respiretory arrest, Approximete Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 4 hours Disease, Chronic Kenal insufficiency 2-3 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 3 years that initiated events resulting in death) Last Qua to (or as a consequence of): ardioni 3years 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Muocard 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 7000 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

item 27 is marked other than "natural", or items 23e or other traumatic event, the Medical Examiner must be re

2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or ite

Jemit. Pages 1 and 2 shc.
Department of Health and M.
Important: If item 27 is meany injury or other

altimore, Maryland 21215-0020

Director

Funeral

þ

Completed

Be

with the Maryland

death

Examiner attending physician and for use as the bunal-transit Physician/Medical þ Completed

2

Certification:

edical

certificate has funeral After

the death certificate be executed Box 68760. Division of Vital Records. or Attending Physician: after death. Director: Aft filled in by Hospital 24 hours completaly

> State Registrar

OCT

1 ☐ Yes

27. Menny of Deeth

2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of continu

wi

1 De Natural

2 No

5 Pending investigation 6 Could not be determined

Hospital:

28a. Date of Injury (Month, Day Year)

1 Impatient

2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

AT2438946-P18

Octo ber

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

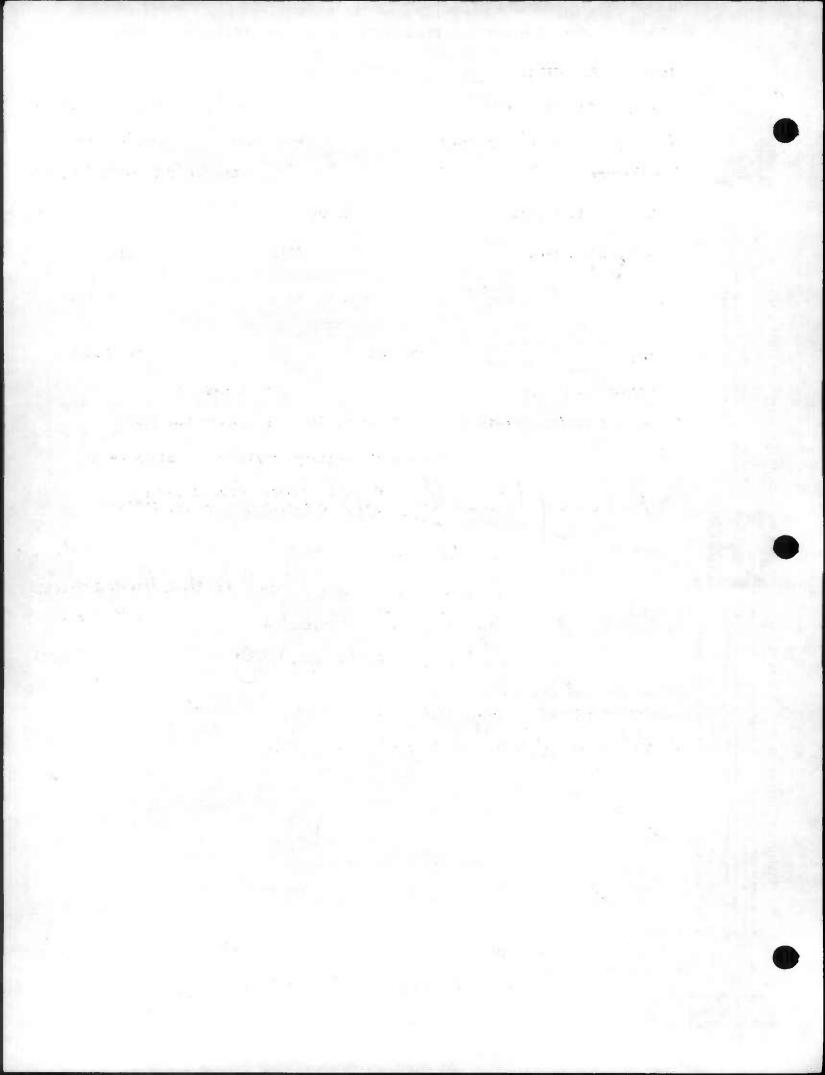
UNIVERSITY PARKWAY DOUYON MP 201 EAST 31. Date filed (Month, Day, Year) 32. Registrar's Signature

8 1999

Wayon, MO

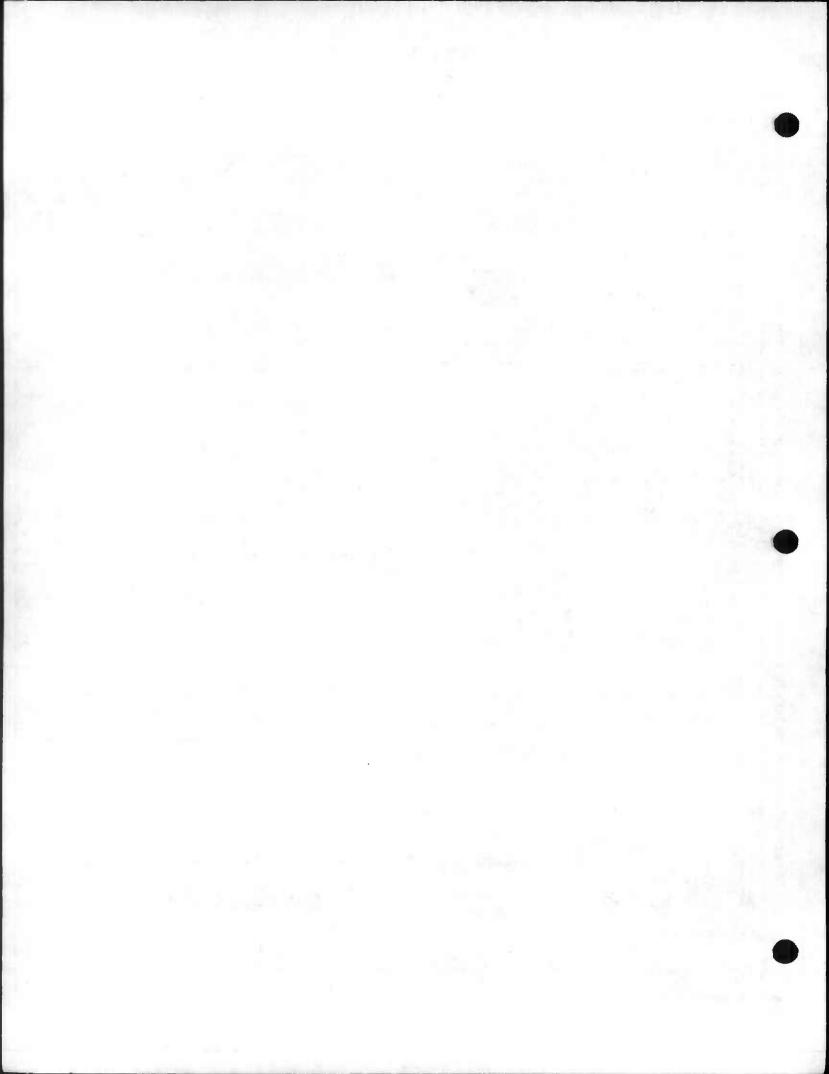
DHMH 16 Rev 6/95

within 2



State of Maryland / Department of Health and Mental Hygiene 9 9 3 | 5 6 6

					Ce	rtificate	of L	Death			Reg. No.				
sician edical	1. Decedent's Na Viol	ame (First, Middle .a.	, Last)	H	la1ey					2. Date of D. OC LODE		99 ğ^{ear}	3. Time of Death 3:36 am		
miner	4a Facility Name (If not institution, give street and number) 4b.							b. City, To	wn, or Lo	cation of Dea	Death 4c. County of Death				
	Freder	Frederick Memorial Hospital Frede							rick		Free				
ral	5. Social Security		6. Sex	-	rs. last birthday)	If Under 1	Year	If Under	24 Hrs.	8. Date of Bi (Month, D			placa (Stata or Foreign intry)		
or	183-07	-7249	1□ M 2□XF	83	Yrs.	Months [Days	Hours	Min.	Oct.	17,191	Mar	yland		
•	Usuai Residence	of Decedent				-									
	10a. State	10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits		
jo	MD Anne Arundel Pasadena											1 ☐ Yes 2\O\No			
r tems 23e or 23e-f sho niner must be nont ed a funeral Director	10e. Street and N	10e. Street and Number 10f. Zip Code									10g. Citizen	of What Cou	intry?		
	257 Carroll Road 21122										USA				
	11. Marital Status		12. Was De Armed F	cedent Ever in	n U,S. 13.				igin? (Sp	ecify Yes or N		Race - Amar			
l	1 Never Ma	er in U,S. 13. Was Decedent of Hispanic Origin? (Specif Yas, specify Cuban, Mexican, Puerto R							Bleck, White	, etc.					
I	3 Widowed	4 Divorced	If Yes, G Year or	2 No live Detes:	1 ☐ Yes 2 ☒ No Specify:						Spe	city: Wh	ite		
ŀ		15. Decedent's	s Education		16a. Dece	dent's Usual (Occupi	ation			16b. Kind o	f Business/le	ndustry		
			t grade completed	•	(Give	kind of work of DO NOT use	done d	furing mos)	t of work	ing					
	12	condary (0-12)	College	(1-4or 5+)	Seamstress						Clot	hing			
		e (First, Middle, L	.ast)		- Count	001000		18. Mothe	er's Name	e (First, Middle		-			
	Eldridge	Jones						Pea	rl						
			in (Tyne Print)		19h Maiii	na Arkkross /S	troot :			al Boute Numi	her City or To	wn State 7	in Code)		
	19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ste Thomas Haley (Son) 257 Carroll Road, Pasadena, MD 21122											<i>p</i> 0000)			
	20a. Method of D	-		201	b. Place of Dispo			,		Date		on - City or T	own State		
			3 Removel from	Chata	cemetery, cres Hillcres	netory or othe	er plac		i	10/07					
	4 Donation	5 ☐ Other (Sp	ecify)												
	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Hardesty Funeral Home, P.A.														
	23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart talium. List only one cause on each line.											MD 21	401		
													Approximata		
	SHOCK, OF TH	DOLL HERWITE. LIST C	They only cause on	eech iine.									interval Between Onset end Deeth		
	Immediate Caus	e (Finai	Ba	CART (7			Ma	4.57	ASIS.		1			
	disease or condi resulting in death	tion 1)	0	C1131 (ANCER O for as a conse	ורוש	7	11/18/	17.3(1	1217.		1			
9					(,									
Examiner			b. 0 E		VENOUS		me	30515	• •			<u> </u>			
-	Sequentially tist if any, leading to cause. Enter Un Cause (Disease that initieted ever	conditions, immediate	D.	Due to	o (or as e consec										
	Cause (Disease that initiated men	or injury	c. 10	LMON		moch	- کد								
	resulting in death) Last		Due to	o (or es a consec	uence of):						1			
			d												
												1			
	Part II. Other sign	nificant condition	ns contributing to	death but not	resulting in the u	nderlying ceu	se give	en in Part i	i.	23b. Did		,	to the cause of death?		
	DEM	ENSTA.								10	Yes 2	o 3□Pr	obably 4 Unknown		
	Aca.	AL FIA	eillattoi	J							s an eutopsy ormed?	8	Vere eutopsy findings veileble prior to		
		1.0										0	ompletion of cause f death?		
	THO	EVY BOC	MARGOTT	A .						10	Yes 2 XX	0 1	□Yas 2□No		
	25. Was case ref		10,000	•				36 Blace	of Doot	h (Check only					
	examiner?	No No	Hospitel:	(Oth	ar.				0.1 (0.	w. h		
	27. Manner of De		-		28b. Time o			4 LINE		me 5 Res 28d. Describe			erry)		
	Naturat	5 Pending		of tnjury nth, Dey Year) Injury	м 250	Worl	k? Yes 2□		200. 0000100	now injury oc	COMEC			
	2 ☐ Accident 3 ☐ Suicide	investige	ot be	a at talian A	4 harman faranca at			760 20		ON Londing	(Ctroot and M	mbar as Ou	cal Davida Mombas		
		4 Homicide 4 Homicide 4 Homicide 28e. Plecs of Injury - At home, ferm, street, fectory, office building, etc. (Specify)							City or To	own, Stete)	iniber or riu	ral Route Number,			
	29a. Certifier (Check only	12 Certifying 2 Medical E	Physician: To the a	basis of exam	cnowledge, death ination and/or in	occurred at a vestigation, in	my or	e, date an pinion, dea	d place, th occurr	and due to the red et the time	cause(s) and , date and ple	manner as ce, and due	stated. to the ceuse(s)		
	one)	4 4/41 4 4/41	and me	nner steted.		100-1	,				00 t D		D. W		
	29b. Signatura er	of the of certifier	1					number			29d. Dete si	gnea (<i>Month</i>	, Day, Tear)		
	7 /	((MA	gende	MI	2	1	00	533	324		10/4	199			
	30. Name and ad	dress of person w	no completed cau	use of death (i	tem 23a) (Type,	Print)						1	1		
	156		CAMOTACO		FRENCE		D	20	-ZI	701	MICH	AEL G	CASAGRAMO		
	31. Data filed (Mo			Registrar's Sig		4									
te ar	00	T 8 10	00 /	eva	4	Land	for t								
	1 11	0 111	LALL I	Part Comment	Comment of	The second secon	110								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #23 PART I, PER MD G77 Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death ANOR 655 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Coumbia If Under 24 Hrs. LORIEN NURSING HOME HOWARD If Under 1 Yaar 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 10M 20F Months Days Hours Min. 243.30.821 Yrs. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No HOWARD MD COLUMBIA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6150 FORELAND GARTH 21045 USA Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married Specify: BLACK 1 Yas 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) ODCIAL DECURITY/WIN 214 ADJUSTER GRADE NIA 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) GREENLEE A DOIEMAE ARNOLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 16TH HARVEY MCCLEUAND 158-31 FLUSHING, NY AVENUE 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 10-9-99 KANDAUSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) PARK KING MEMORIAL 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility VAUGHN C. GREENE VAUGHN 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or hiteral failure. List only one cause on each line. mo. Approximate Interval Between Onsat and Death END STAGE RENAL DISEASE Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of) HYPERTENSION Dua to (or as a consequence of). Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes ANO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyas 2 No

Physician /Medical Examiner

attending physician and for use as the burial-transit

by

Completed

Be

this After this funeral

To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera

edical Certification: To

29a. Cartified

the death certificate be assecuted

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Department of Health and Meniel Hygiens.
Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Examples must be notified at each.

Itlmore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

2 No

26. Place of Death (Check only one)

25. Was case refarred to medical axaminer? Hospital: Other: Nursing Homa 5 Rasidence 6 Other (Specify) 1□ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Natural 5 Pending investigation 1 Yes 2 No

2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and piace, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifien

29c. License number

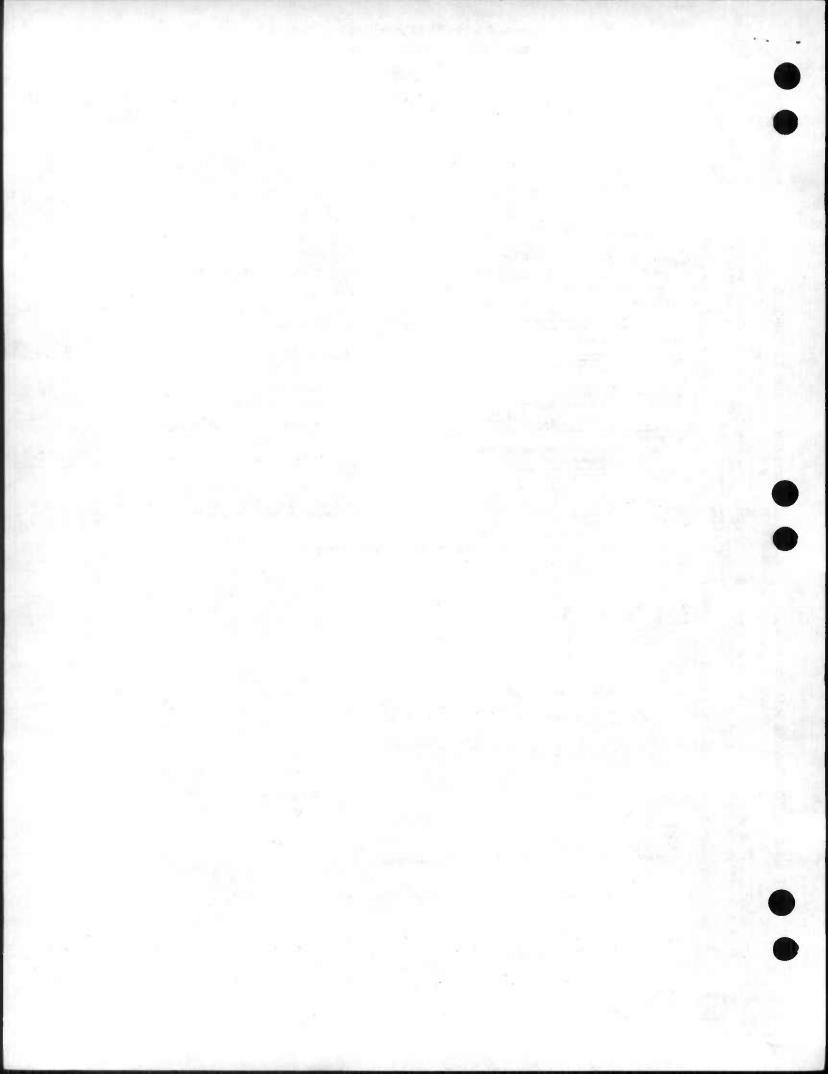
29d. Data signed (Month, Day, Year)

ed causa of death (Item 23a) (Type, Print)

COLUMBIA, M& 21045 Pedman KNOLL N. arrhall D. O 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

8



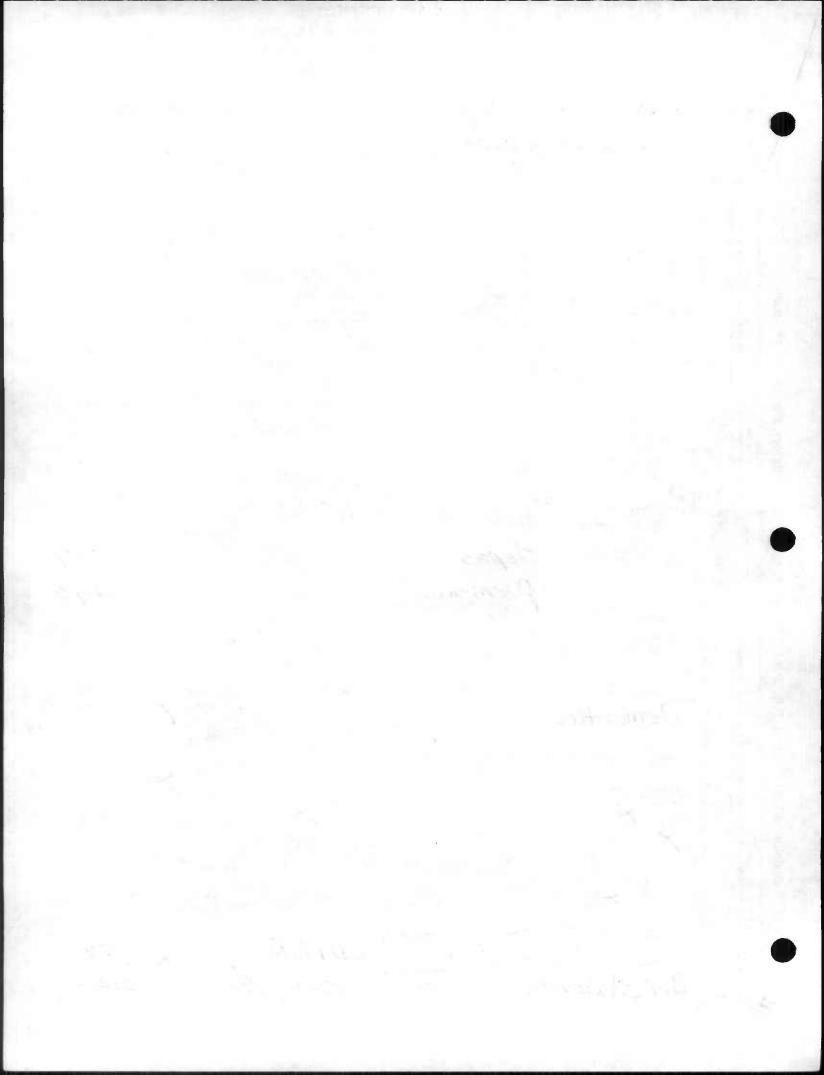
Piease Type or Print in Biack indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:20 AM 10 99 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A 21 Hours Min. 8. Date of Birth (Month, Day, Year) OCT. 13, 1903 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 💢 F 218-01-5587 Yrs 95 Director Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland N/A Baltimore 1 X Yes 2 □ No Director 23s or 28s-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Melrose Ave. 21212 115 E. U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Nems Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Clerk City Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ound be the and Mental F Be Hogg Jacob Mary Burns 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as Important; if item 27 is any injury or other trau Robert Krichton (nephew) 521 Country Ridge Circle, Bel Air, MD Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from Stete Most Holy Redeemer Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 10/5/99 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner The lew requires that the death certificate be axecuted burial-transit monis Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of) Box 68760. signed by the ettending physician d be deteched for use as the burie Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2/3/40 3 Probably 4 Unknown 1 Yes Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? page 2 should hes this certificate 1 Yes DINO 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner?

1 □ Yes Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient Other: State of Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) funaral 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury 6 Work? Affer 5 Pending investigation Netural To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af complistely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of per 29d. Date signed (Month, Day, Year) 30. Name an leted cause of der 32. Registrer's Sigi State

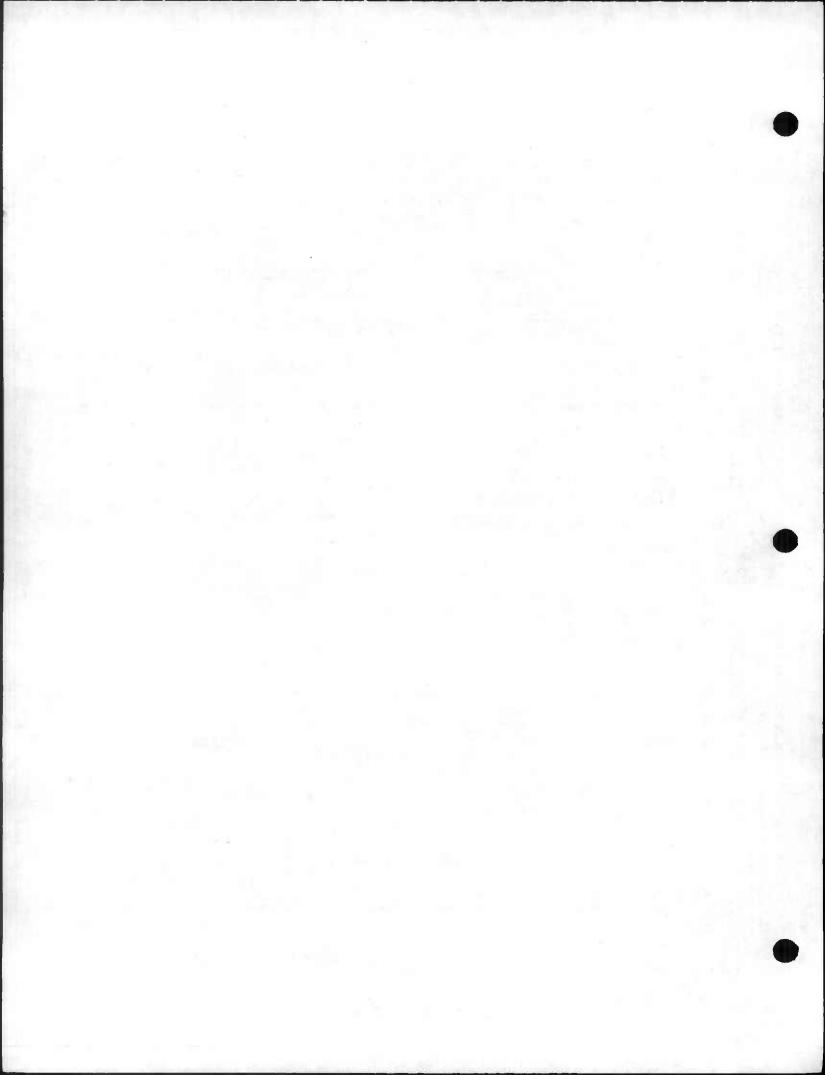
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Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 3 1 5 6 9

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Examin	4.	Facility Nama (If not institution, giv	e street and number)				4b. City, Town, or	Location of Death	4c. County	of Death	1	
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Funeral Director		210-10-0940	ex 7. Ag	ler 1 Year s Days	If Under 24 Hrs Hours Min.		Year) 922	9. Birthpi Coun Mari	lace (Stete o try) Yland	v Foreign		
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OZ CE	by Fur	. Marital Status 1 Never Married 2 Merried 3 Midowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:				Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American India Bleck, White, etc. Specify: White			
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the The other		a. Method of Disposition		20b. Place	of Disposition (N ery, cremetory or	leme of	Roua, CC		20c. Location -			
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The law ate has page 2	E							1 □ Y	es 2 XNo	10	Yes 2□	No
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Physician: this certific nal director.	10	examiner? 1⊠'Yas 2□ No	Hospitet: 1 ☐ Inpatie	ent 2 ER/O	Outpatient 3 2	DOA Oth	ner: 4 Nursing I	Home 5 ☐ Reside	ence 6 Oth	er (Specify	y)	
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of the of the ompi		29b. Signature and title of certifier 29c. License number 29d. Date signed (Mi										
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[0.	30	Name and address of person who	completed cause of d	eath (Item 23=)	(Type Print)	010	100	10	icto be r	6,1	179	
V.	7	Lilip Militello	M.D. SHO	, cly Tr	auma	22	S. Gree	ene ST. Be	Himore	Md	2120	1
State		Date filed (Month, Day, Year)	completed cause of d	are Signature	9. An	21/2	/			4		-



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Day JAMES 1:30 PM **HESS** 1999 OCTOBER 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death DUNDALK HERITAGE NURSING CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 6. Sax 1 → M 2 □ F 7. Aga (In yrs. last birthday) Birthplece (Steta or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Months Days Yrs. 213 09 0797 91 MARYLAND Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No **EDGEWOOD** HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 USA 1818 STEVEN DRIVE 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coltege (1-4or 5+) STEEL 6 MACHINIST 18 Mother's Name (First Middle Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) SHORE FREDERICK LENA **HESS** 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Catherine Hagan / daughter 2612 Franklinville Rd. Joppa, MD 21085 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 ☐ Cremation 3 ☐ Removel from Stete OAKLAWN CEMETERY BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237 23a. Part 1. Enter the disease, or complications the caused the that Do not antar tha mode of dying, such as cerdiec or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Death Immediete Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in death) Lest o (or as a consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 1 Yas 2 No 25. Wes case referred to medical exeminer? 1 ☐ Yes 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

injury or

any.

Physician

* /Medical

Examiner

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Completed

10

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

pernit. Peges 1 and 2 should be filed within 72 hours after or Department of Health end Mantel Hygiane. Intern 17 is marked other than "natural", or Ne

altimore, Maryland 21215-0020

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physician and the burial-transit funeral director,

27. Manney of Death

Natural

2 Accident

3 Sulcide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature end title of certifian

the death certificate be executed Box 68760, detached P.O. signed by 1 d be detach Division of Vital Records, Attending Physician: Certification: To this After • Hospital or Attending 24 hours efter death. completely filled in by

> State Registrar

Medical

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 Could not be determined

32. Registrer's Signature

28a. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work?

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number

1 Yes

2 No

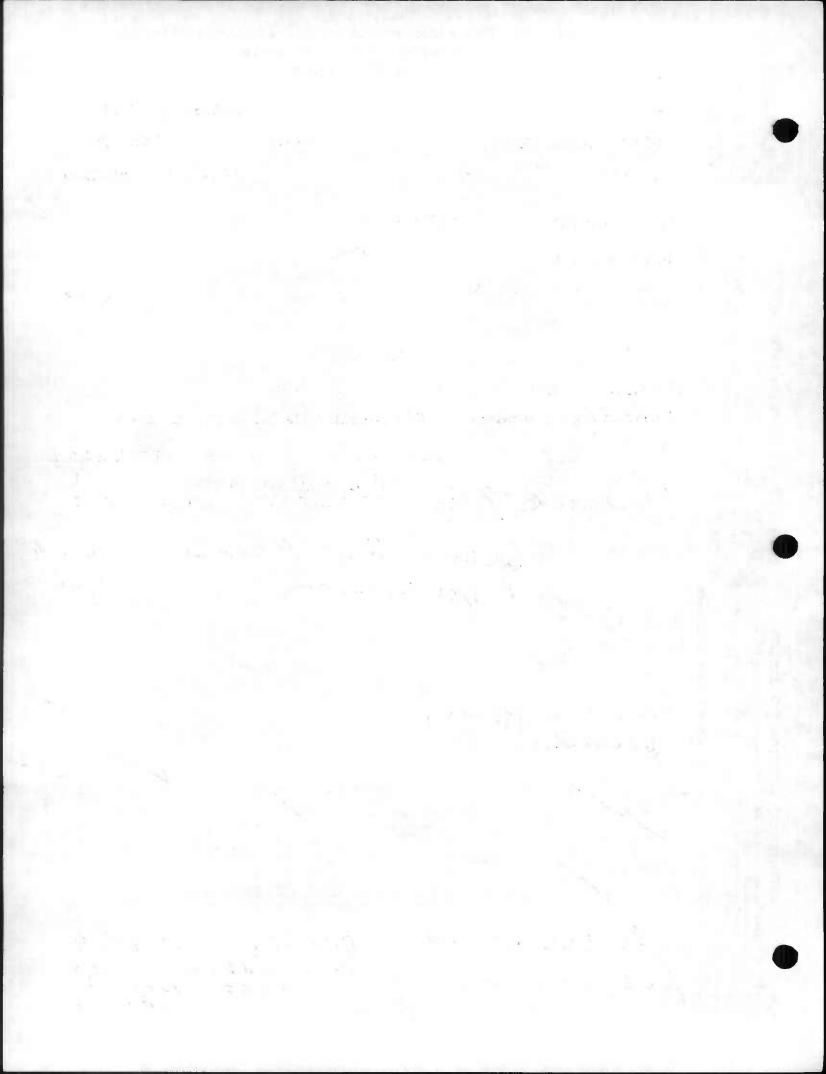
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28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Straet end Number or Rurel Route Number, City or Town, State)

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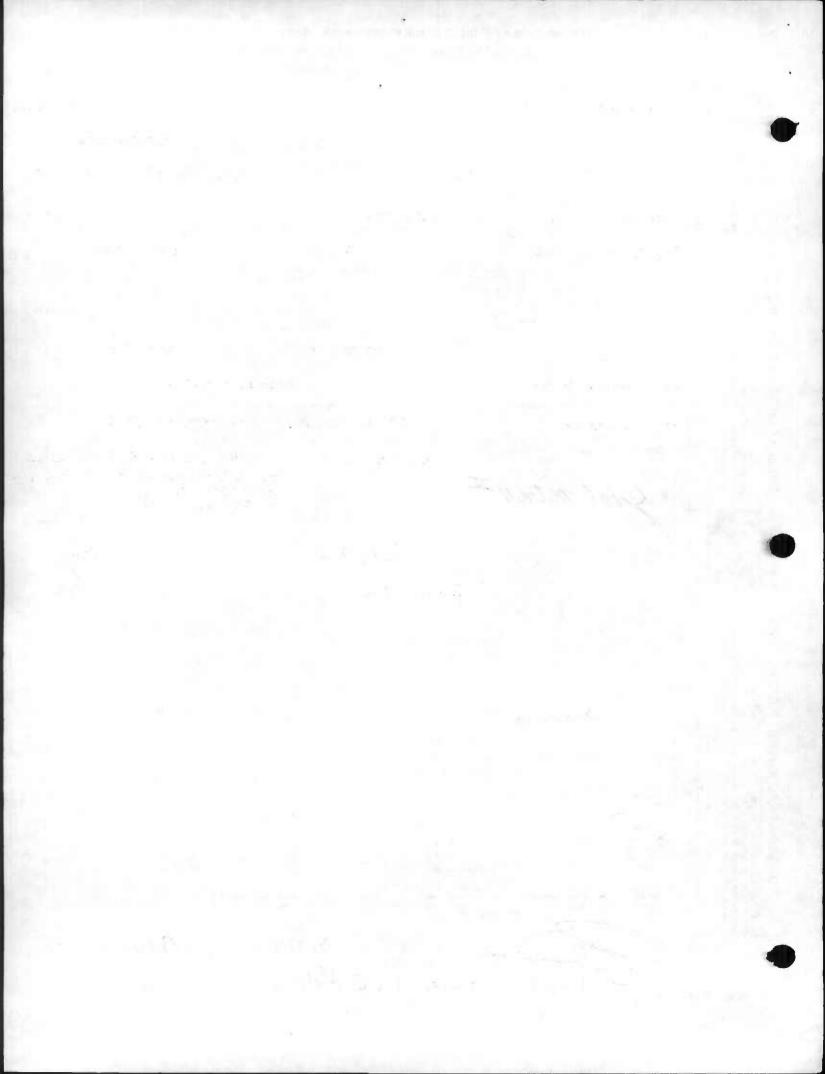


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dey Yeer **Physician** 10:15pm -1999 Pecuri Ives 10 /Medical 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltina If Under 24 Hrs. Baltimore Long Green If Under 1 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours Min. Yrs. 220-46-0334 April 16, 1903 Connecticut Director Usuel Residenca of Decedent with the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. inside City Limits Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan nent of Health and Mentel Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-1 show ary or other traumatic event, the Medical Examinating to nourised. N/A Baltimore 1XXYes 2 □ No Maryland Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21212 United States 115 E. Melrose Ave. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: white þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Neme (First, Middle, Melden Surneme) 17. Fether's Neme (First, Middle, Last) Irene B. Blatchley Henry Benton Putney 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Baltimore, MD 802 Kingston Rd. Paul P. Ives/son 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Bunal 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) permit. Page Department of important: If any injury or pace. 10/8/99 Guilford, Connecticut Alderbrook Cemetery 22. Name and Address of Facilit Mitchell-Wiedefeld Funeral Home, Inc 21. Signeture of Funeral Service Licensee 6500 York Rd. chy 6. Mitchel Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel PSIS da diseese or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner Discump N. a that the death certificate be executed physician and s the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Dee to (or es e consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 60 US8 signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Demonta à 24b. Were eutopsy findings eveilable prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? page 2 certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Investigation Naturel 1 TYes 2 □ No death. 2 Accident after deatl 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) filled in • Funeral (Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and little of certified 29d. Date signed (Month, Dey, Year) 29c. License number 30. Nar wno completed cause of deeth (Item 23e) (Type, Print) Schwarfems 32 Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month JOHNSON EDWIN 20.50 Oct /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GOOD SAMARITAN KOSPITAL BALTIMORG BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, 12-10-7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country)
 M D **Funeral** 1√2 M 2□ F Months Deys Hours 212-34-6116 63 Yrs. Director Usuet Residance of Decedent the Marylend 10e Stete 10b County 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD NA Baltimore 10e. Straat end Number 10f. Zip Code 10g. Citizen of Whet Country? filed within 72 hours after death with 5220 York Road 21212 USA Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X X No If Yes, Give Year or Detes: than "natural", or items the Medical Examiner ma 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritei Status 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 X Divorced Black Completed 16a. Decedant's Usuel Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-employed in & out of home i. Pages 1 end 2 should be filed w tment of Health end Mental Hygie tant: If item 27 is marked other ti jury or other traumatic event, to 5th Grade Baltimore, Maryland 17. Fether's Neme (First, Middla, Last) Be 18. Mother's Name (First, Middla, Meiden Sumeme) Edwin J. Johnson, Sr. Virginia Smith 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) 21218 Mary Rich + Eugene Johnson 601 Wyanoke Avenue Apt. #420 Baltimore, MD 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of important: if any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 10-09-99 Lansdowne, MD 21. Signeture of Funerei Service Licenses 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue anti. Enter the diseas shock, or heart failure. leath. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete tntervel Between Onset end Death **Physician** /Medical Immediete Cause (Finel a PNEUMONIA disease or condition resulting in death) 2 weeks Examiner Due to (or as e consequance of): Examiner D. CHRONIC OBSTRUCTIVE PULMONARY DISEASE The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceusa. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest use as the buriel-trar Due to (or as e consequence of). P.O. Box 68760, Physician/Medical Due to (or es e consequance of): detached Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of death? signed by 10 Nos 2 No 3 Probably 4 Unknown COROWARY ARTERY DISEASC Records, þ Completed 24b. Wara eutopsy findings eveileble prior to complation of ceuse of daath? 24a. Wes en eutopsy performed? DILATED CARDIO TYOPATHY 1 ☐ Yes 2 No 1 ☐ Yes 2 No of Vital or Attanding Physician: Be 25. Wes case refarred to medical 26. Place of Deeth (Chack only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yas 2 No 1 Appatiant 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28e. Deta of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury et Work? 5 Panding Investigation 1 Naturel Division s efter death. 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) illed in by 4 I Homicide To the Hospital within 24 hours of To the Funeral L Medical 29a. Certifier 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Exeminer: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and mannar stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct 4,1999 30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print)

NOUMAD DAMAS/600 SAMARITAN HUSPITAL

6501 LOCH DAVEN BLVD BALTITURE TO 21239 32. Registrar's Signeture State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - KYON Month :48m Day **Physician** Sofember 25 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 → M 2 □ F Yrs. Director 70 5, 1929 216-24-9911 unknown Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If firm 27 is marked other than "natural", or frems 23a or 23a-f show any injury or other traumatic avant, its structure in mast be notified. 1 No 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 S. Castle Street 21231 unknown Funeral 12. Wes Decedent Ever in U,S. Armed Forces? unknown 1 ☐ Yes. 2 ☐ No If Yes, Give Year or Dates: 14. Raca - American Indian, Black, White, etc. 11. Meritel Status unk nown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced unknown Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unknown Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be 0 unknown unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location · City or Town, State cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Ronald S State Anatomy Board, 655 W. Baltimore Street Director Cille Blatimore, MD 21201 23a Fant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, about, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be asscuted physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Records, P.O. Box 68760. IGOXIN TOXI Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by ate has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 20 No 1 TYes 1 Yes 2 No certificate Division of Vital Hospital or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mb 1 | Inpatient | DER/Outpatient 3 | DOA edical Certification: To After this lilled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred NA 5 Pending investigation Natural Injury NA NA 1 Yes 2 No death. NA 2 Accident within 24 hours aftar deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completaly ŝ 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) G

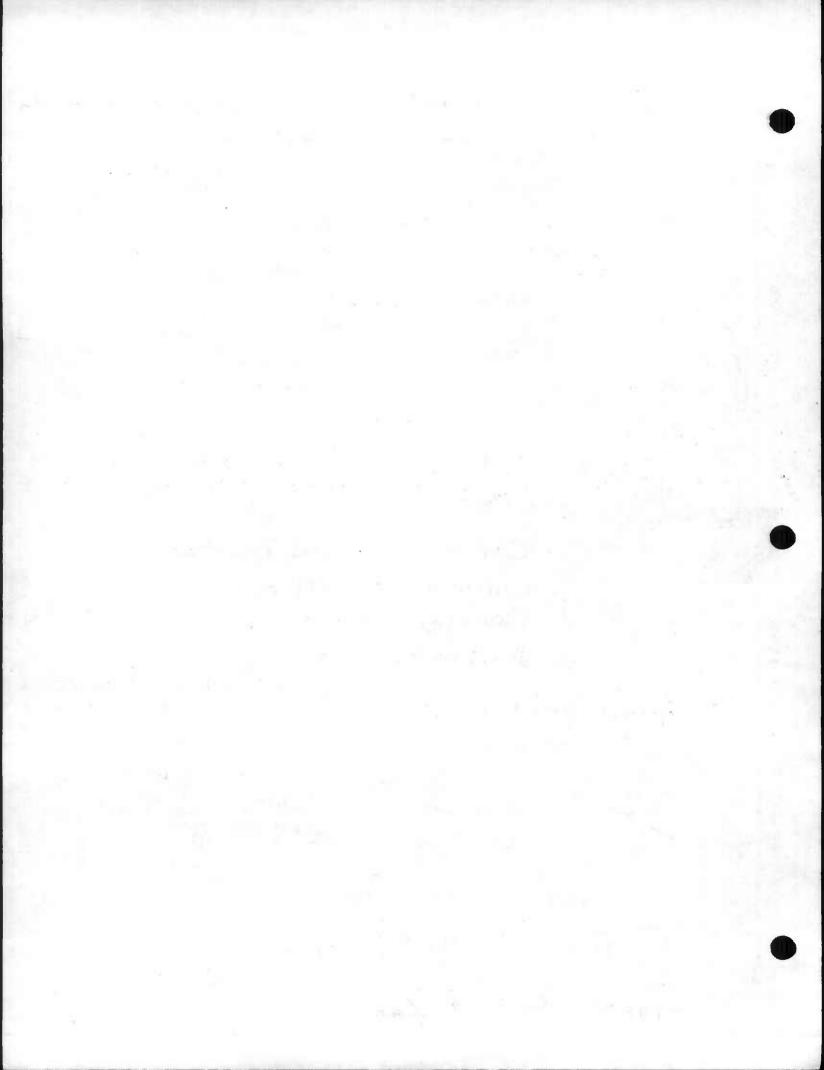
DHMH 16 Rev 6/95

State Registrar MD

32. Registrar's Signature

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ULIAN 31. Dete filed (Month, Dey, Year)
OCT 0 8 1999 AL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician /Medical Examiner Sex 100 M 2□ F If Under 1 Year 7. Mge (In yrs. last birthday) **Funeral** Deys Months Hours Director idence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland neat of Health and Mental Hyglene.
ant: If fem 27 Is marked other than "natural", or items 23s or 28s-f show ury or other transmit be notified a 10b. County 10d. Inside/City Limits 1 Yes 2 No Director 10e. Stre et and Nu 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) PCes? White, etc. 1 Never Merried Baitimore, Maryland 21215-0020 1□ Yes 2 No by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) 6 dery (0-12) College (4-for 5+) (First, Middle, Last) Mothar's Nama (First, Middle, Maiden Sumam 300 . MD 20b. Plece of Disposition cematary, cremator thod of Disposition Department of Important: If It eny Injury or o Burial 2 Cremetion 3 Removel from State 4 Donation 5 □ Other (Specify) 21. Signeture of Funerel Service Licens 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be axe Box 68760. the Due to (or es e consequence of): for usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. 3 □ Probably 4 □ Unknown 1 Yes 2 No Medical Certification: To Be Completed by 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 20 No 1 Yes or Attending Physician: 25. Was casa referred to medical examiner? 26. Pleca of Death (Check only one) 1□ Yes 200 Other: Nursing Home 1 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Data of Injury (Month, Day Year) 27. Manner of Death
1 Description
2 Accident 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 24 hours after death.

Funeral Director: A 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et the time, dete end placa, end due to the cause(s) end menner stefed.

within 2 the

> State Registrar

29b. Signature end title of certified

I an mora

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 16 Rev 6/95

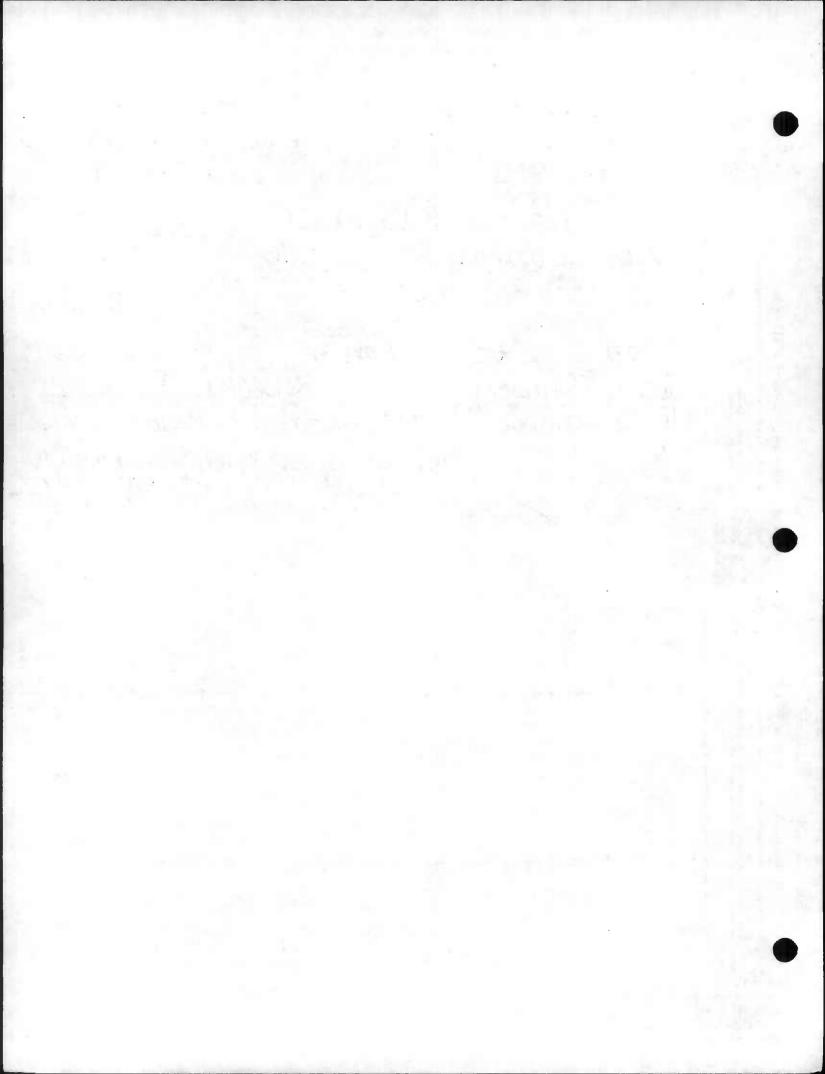
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29d. Deta signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene o

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То	19e, Informa	nt's Name/Rete	tionship (Ty	pe, Print) <mark>S</mark> i	ster				and Numbe	r or Aur	al Route Num)
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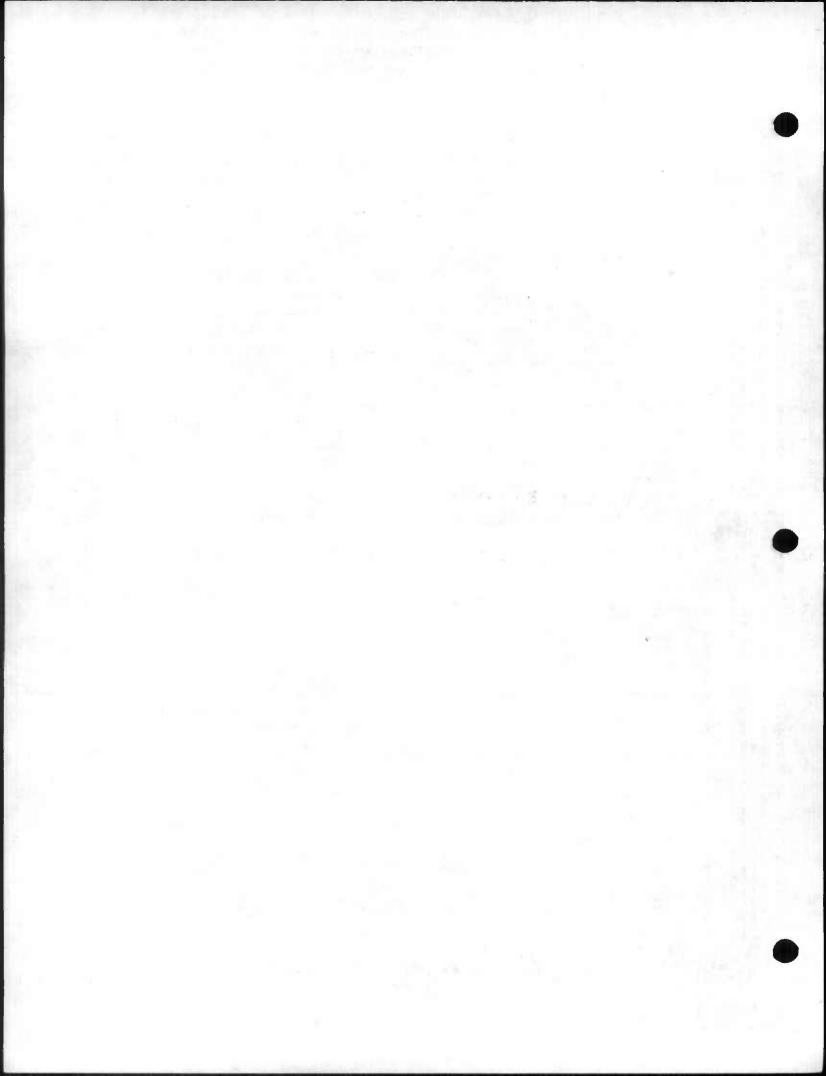
Cynthia yores October 2, 1999 8 15am

31. Date filed (Month, Day, Year)
OCT 8 1999 State Registrar

30. Name and address of person who completed cause of death often 23a) (Type, Print)
11) A. R. Ley GBMC 6701 N. Charles St. Balto. and 21204 82. Registrar's Signeture

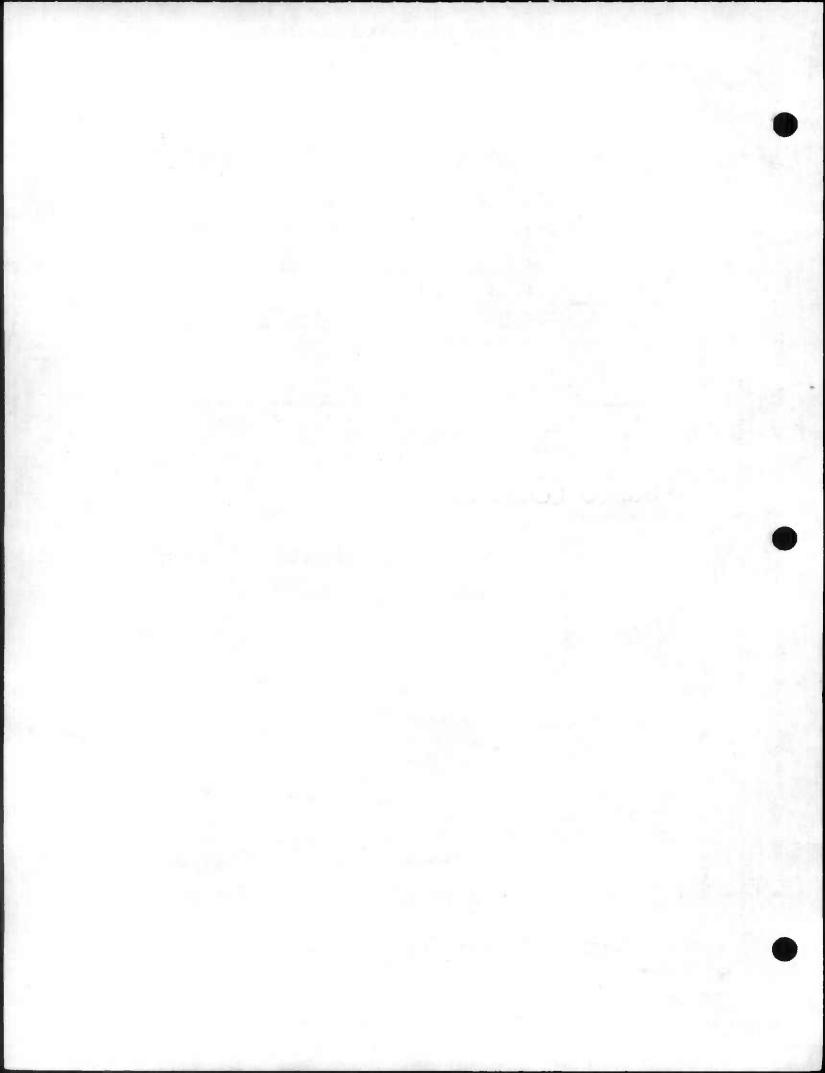
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October 2, 1999



State of Maryland / Department of Health and Mental Hygiene Q Q Q 1576

			Certificate of	Death	Re	g. No.	31310
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/Medica	Macarea Anna				October	7, 1999	
Examine				4b. City, Town, or L		4c. County of	
	Gilchrist Cent 5. Social Security Number 6. S		ast hirthday) If Under 1 Year	Tows on	_	Balti	
Funeral Director	085-07-4042	ex	Yrs. Months Deys		8. Date of Birth (Month, Day, July 5,	Year) 1917 N	Birthplace (State or Foreign Country) Waryland
B R	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
with the Marylar a or 28a-f show be notified at	Maryland Baltimo	re	Kingsville				1 ☐ Yes 2 🕍 No
	1 1 7 7 7 5 1 7 7 7 7 1 1	e	10f. Zip Code	21087	10	g. Citizen of Whe	
5-0020 72 hours after death values, or Neme 23 licel Examiner must	3. Widowed 4 □ Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cul		pecify Yes or No- Rican, etc.)		American Indian, White, etc. White
21215-0 od within 72 ho od within 72 ho or than "nature t, the Medical.	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usual Occu	pation during most of work	kina 1	6b. Kind of Busin	ness/Industry
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A partie of			Clerk	40 Mathada Nam	e (First, Middle, M	Governm	
Maryland 21215-0020 3 2 should be filed within 72 hours at h and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by	August Kotsche	nreuther			Hoffstee		
Mary nd 2 sho uth and it 27 is me	19a. Informant's Name/Relationship (1 Mrs. Lois K. She		19b. Mailing Address (Stree 11203 Lynn I				
of Hear	20a. Method of Disposition	20b. Pla	ace of Disposition (Name of ametery, crematory or other plants	aca)	Date 2	0c. Location - Cit	ty or Town, State
attimore mit. Pages 1 partment of Hi portant: if len y Injury or oth	1 ⊠ Buriat 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Memovat from State	idon Park Ceme		0/11/99 B	altimor	e, Maryland
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Physician	shock, or heart failure. List only	one cause on each tine.					Interval Between Onset and Death
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er this seral d		28a. Dete of fnjury	28b. Time of 28c. fnje	1	28d. Describe how		-//-/-
Attending in death. Sector: After by the funerial death.	Neturat 5 Pending 2 Accident Investigation	(Month, Dey Year)		Yes 2 No			
be or Attending P is after death. In Director: After led in by the funer. Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fectory, office		281. Location (Str. City or Town,	set and Number Stete)	or Rural Route Number,
Hospi 4 hou Funer laky fill		/alcian: To the best of my know iner: On the basis of examinati and manner stated.					
To the Vithin 2 To the comple			29c. Licen	se number	29	d. Date signed (Month, Day, Year)
	> milter o	2. Melyno 1	MP D	12030		or 7,	1999
4	30. Name and address of person who of WALTER R WELZ		23a) (Type, Print) 00 OSLER DR	STE 107	TOWSO	N, MD.	21204
State Registrar	31. Date fited (Month, Day, Year) OCT 8 199	32. Registrar's Signate	G. Sparks				
DHMH 16 Bay 6/95		1	14. Moules				



RE	D)	PIE 11/03/99 E	State of	Maryland	d / Depa	artment o	of I	lealth an	d Mental H	lygiene Reg. No. 9	9-3	1577
Physic		Decedent's Nema (First, Mid BEATRICE	dle, Last)	KOBRIN					2. Date of Month OCT .	Death Day	1999	3. Tima of Death 12:30PM
/Medi Exami		4a Facility Nama (If not instituti	mark warner					6b. City, Town, BALTIM	or Location of De		nty of Death	
Funeral Director		5. Social Security Number 196-07-2453	-	7. Age (In yrs. Is 80		If Under 1	Year	If Under 24		Birth (Year) 19,1919		place (State or Foreigntry)
death with the Maryland ma 23a or 28a-f show	tor	Usual Rasidence of Decedent 10a. State 10b. Count MD BALTII	•		Town or Lo	cation LSTOWN						10d. Inside City Limits
io after death with the Maryle or Neme 23s or 28s-1 shor	al Director	10e. Street and Number 9612 ORPIN RO	AD #201			10f. Zip Co	ode 113	33		10g. Citizen	of What Cou SA	ntry?
5-0020 72 hours after deal natural; or Neme 2	by Funeral	11. Marital Status 1 Nevar Merried XX Me 3 Widowed 4 Divorce	Armed Ford	2/ No		Vas Deceder I Yes, specify I Ves 2E		lispanic Origin an, Maxican, P Specify:	(Specify Yes or uerto Rican, etc.)		Race - Ameri Bleck, White cityWHIT	etc.
T. 5	Completed	15. Deceds (Specify only high Elementery/Secondary (0-12)	nt's Education est grede completed) College (1-	4or 5+)	(Give . life. E	lent's Usual C kind of work o DO NOT use LES	Decup done retired	etion during most of d)	working	16b. Kind o	(Business/Ir	ndustry
	o Be C	17. Fathar's Nama (First, Middle JACOB	a, Last)		KL:	INE		18. Mother's REBECC	Name (First, Mide	dle, Maiden Sun		ILBERG
Marith are traus	Ţ	19e. Informant's Name/Reletion SANDRA FRIEDMAI		R	19b. Mailin	g Address (S		and Number o	Rural Route Nu		wn, State, Zi	p Code)
e Tare		20a. Method of Disposition 1 □ Burial 2 □ Cremetion 4 □ Donetion 5 □ Other (3 ☐Removel from S	20b. Pla	ace of Dispo	sition (Name natory or othe NAH AI	of or place	ce)	Date	_	on - City or T	own, Stete
Baltimo Baltimo Baltimo Beamir, Page Important: If Importa		21. Signature per uneral Service 25. Part I. Enter the disease, abook, or heart failure. Life Immediate Causa (Final disease or condition resulting in deeth)	or complication that can all only one catus on ee	enoca	890 Do not ente	er the mode of	STE of dyin	RSTOWN ng, such as car		KESVILL		
BOX 68/60, Seath certificate be executed a attending physician and d for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daeth) Last	6. Ca	stric	as a consequence as a consequence	uence of):	W	er.				years
D.O. do the do the dotache	Physician/Medical	Part II. Other significant condit	lone contributing to dea	ath but not resul	iting in the ur	nderlying cau	se giv	en in Part I.		id tobacco use		to the cause of death
Of VICEI RECOIDS, P. Physician: The lew requires that this certificate hes been signed i	Completed by									as an autopsy enformed?	81	Vara autopsy findings vailable prior to ompletion of cause I death?
VITAL Medicalent That is to certificate hes rector, page 2		25. Was case referred to medic	al					26 Diago of	Death (Check on	Yes 2014	1	☐ Yes 2☐ No
- 0 0 0	tion: To Be	axaminer? 1 Yes 25 No 27. Manner of Death 1 Naturel 5 Pand	Hospitel: 1 ☐ In		R/Outpatien 28b. Time of Injury		Oth Injur Wor	er: No Nursi	ng Home 5□R			ity)
DIVISION of or Attending stater death. I Director: After od in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	mined 288. Plece 0	of Injury - At hor g, etc. (Specify)	ne, farm, str	set, factory, o	office		28f. Locatio City or	n (Street and N Town, Stata)	umber or Ru	ral Routa Number,
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	edical	(Check only 25 Medica	ing Physician: To the bas il Examiner: On the bas end menns	pest of my know sis of examination or stated.	ledge, death on and/or inv	restigation, in	my o	pinion, death o	lace, and dua to t occurred at the tin	ne, data and ple	ce, and dua	to the cause(s)
To Too	×	29b. Signature and title of certification of the control of the co	-mg	And of them :	23a) (Type, I	0.	3 g	9943		29d. Date si	gned (Month	, Day, Year)
Sta	ate	31 Date filed (Month, Day, Year	Lay DI	gistrar's Signatu								
Registr		00	T 1 8 1999	ips	var	Ŋ.,	de	rocks				

JEFFRY KATZ

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician JEFFRY** KATZ 4, 1999 0255 AM OCT. /Medical 4a Facility Name (If not Institution, give street and number)
I#495 NORTH—SOUTH OF RITCHIE ROAD 4c. County of Death
PRINCE GEORGES 4b. City, Town, or Location of Death Examiner FORESTVILLE 5 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1M M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs. 358-54-1954 Director 36 MAR. 2, 1963 IL Usual Residence of Decedent the Meryland 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow so filed within 72 hours efter death with the Meryle al hygiene. I other than "natural", or frame 23s or 28e-f show I want, the Medicel Estimate must be motified. IL COOK CHICAGO 1 XYes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3843 N. LOWELL STREET 60641 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HORSE TRAINER HORSES. permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other any Injury or other traumatic avant, page. 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 SUMNER N. KATZ ROSALIE PODRACHICK 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) SUMNER N. KATZ / FATHER 1278 BARCLAY BOULEVARD - BUFFALO GROVE, IL 60089 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Memoval from State NEW TIFERETH ISRAEL 4 ☐ Donation 5 ☐ Other (Specify) 10/5/99 EVERETT, MASS. 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Causa (Final diseasa or condition resulting in death) /Medical . HEAD DUD NEW the way Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Due to (or as a consequence of) USB BS Box P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records. þ 24a. Was an autopsy performed? 24b. Wara autopsy findings availabla prior to completion of cause of death? Completed paga 2 2 No 1 Nes 2 No of Vitai 25. Was casa raferred to medical axaminer? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence Nother (Specify) AT SCENE X⊠Yes 2□ No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 Pending investigation Division Attanding 1 DNátural DRIVER OF CAST, STRUCK BY WHICH 281. Location (Street and Number or Rural Route Number, City or Town, State)

I 49 TD _ Pri 405 G & DRW3 W W s after deeth. FOUND 10-4-99 0246 1 Yes 2 No 2PI Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 5 TY9TD_Fruce q erofus to a stated.

| Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | Type | 24 hours To the Hospital within 24 hou To the Fune complately fil 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCT. 4, 1999 O.C.M.E and address of person who completed cause of death (Item 23a) (Type, Print) 1 My Daim

State

Registrar

31. Date filed (Month, Day, Year)

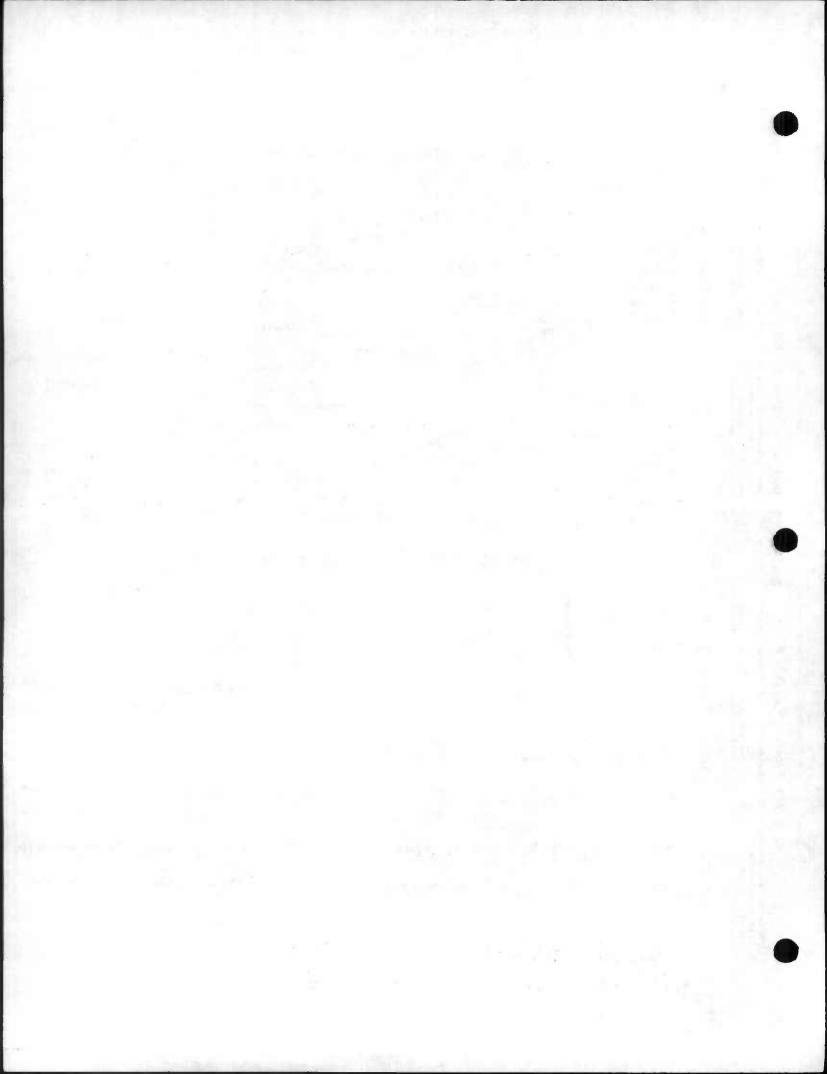
OCT

8

1999

32. Registrar's Signature

A. Kontu Mull1 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death KLEIN **Physician** SIDNEY 1905 PM OCTOBER 1955 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE RANDALITUNN HOSPITAL NORTH WEST Hunder 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) JAN 17, 1920 7. Age (In yrs. lest birthday) If Under 1 Year 6. Sex. 1 ☑ M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months Deys 79 Yrs. Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Neme 23a or 28a-f show traumatic event, the Modical Examinat must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12 STONEHENGE CIR., #5 21208 USA Funeral permit. Pages 1 end 2 should be filed within 72 hours efter deat Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural". A page. any injury or other traumetic event. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14 Rece - American Indian Bleck, White, etc. 1 Never Merried 2 Merried 1 DYes 2 RMY If Yes, Give ARMY Yeer or Detes: WWII 1 ☐ Yes 2 XNo Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) SALESMAN CLOTHING 18. Mother's Nama (First, Middle, Maidan Surnama) 17. Fether's Neme (First, Middle, Last) Be 2 JOSEPH KLEIN SARAH 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) BALTO., MD 21208 ate 20c. Location - City or Town, State SARAH KLEIN (WIFE) 12 STONEHENGE CIR., #5 20e. Method of Disposition 20b. Placa of Disposition (Name of cametary, crametory or other place) 1 N Buriel 2 □ Cremetion 3 □ Removel from State OHEL YAAKOV BETH ISRAEL 10/5/99 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signeture of Funeral Service Licenses 22 SOL or LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Pert1. Enter the disease. It complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or it art feilure. List only one cause on each line. Onset and Death **Physician** SEPSIS /Medicai Immediate Ceuse (Final disease or condition rasulting In death) Examiner Due to (or es e consequence of): Examiner CRYPTO COCCAL Dua to (or es e consequenca of): physician and the burial-transit Sequentietly list conditions, if eny, leading to immediate causa. Entar Undarlying Ceuse (Diseese or Injury that initiated avants resulting in deeth) Lest AIDS Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): esn Pert it. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknown CMV δ 24b. Ware eutopsy findings eveileble prior to 24e. Was en eutopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Minpatiant 2□ ER/Outpatient 3□ DOA P 1 Yas 2 No 27. Manner of Deeth 1. Dilaturel 2 \sum Accident 28d. Describe how Injury occurred 28a. Data of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? Certification: 5 Pending invastigation 24 hours after death. Funeral Director: Af 1 Yas 2 No 6 Could not be datarmined 28e. Plece of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end manner as stated. 2 Medicat Examiner: On the basis of examinetion end/or threstigetion, in my opinion, daeth occurred et the time, dete end plece, and due to the cause(s) end manner stated. 29a. Cartifian Medical (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number OCTOBER 3, 1998 1)77733

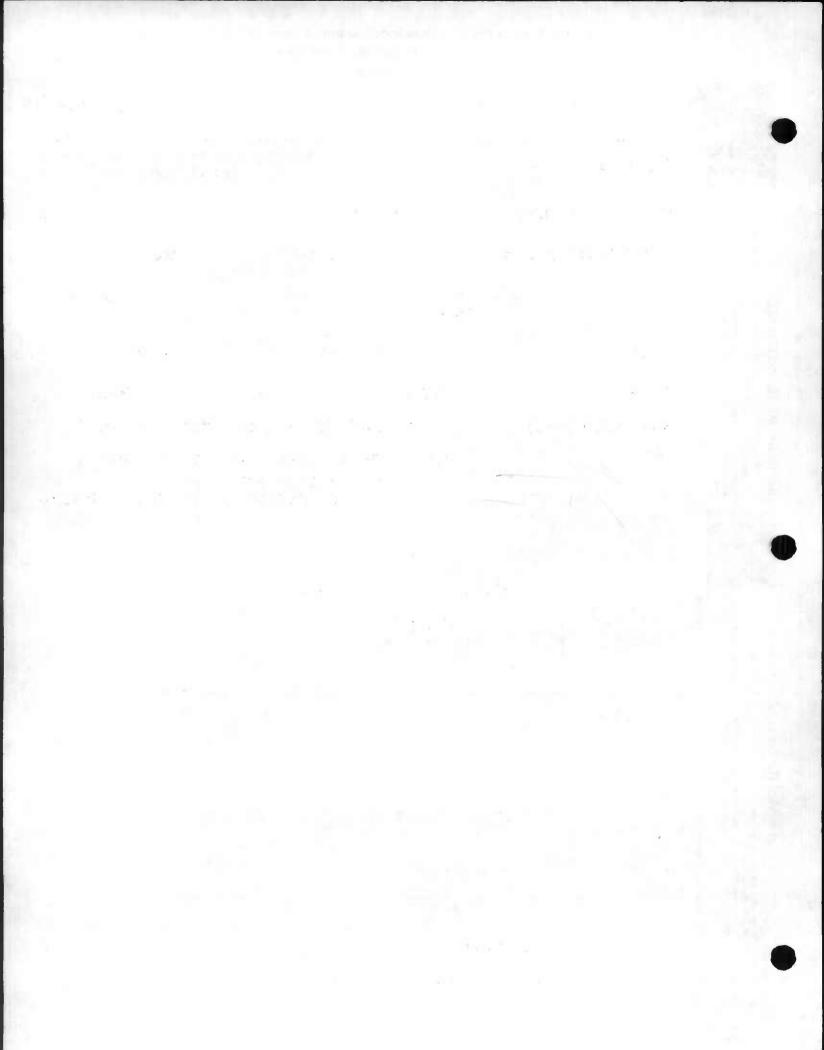
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31. Dete filed (Month, Day, Yeer) 0CT 8 1999

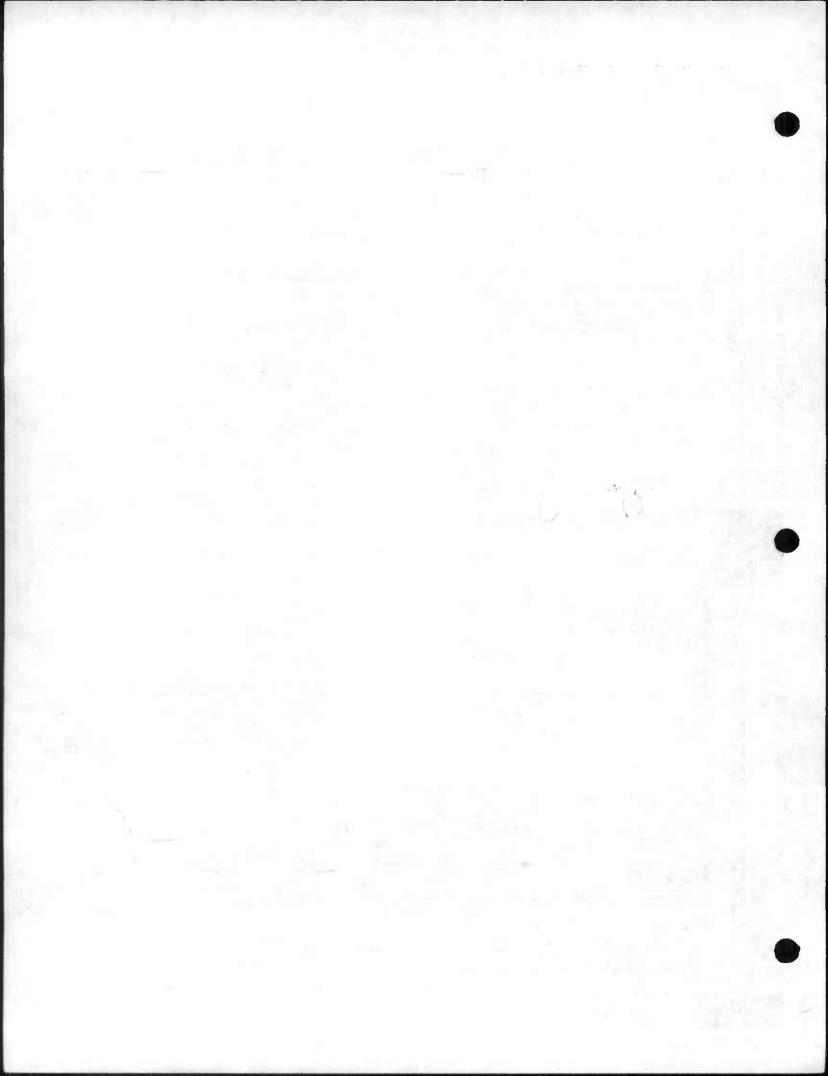
C. RAVI

NHC, BALTO. MO 21137 32. Registrer's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)



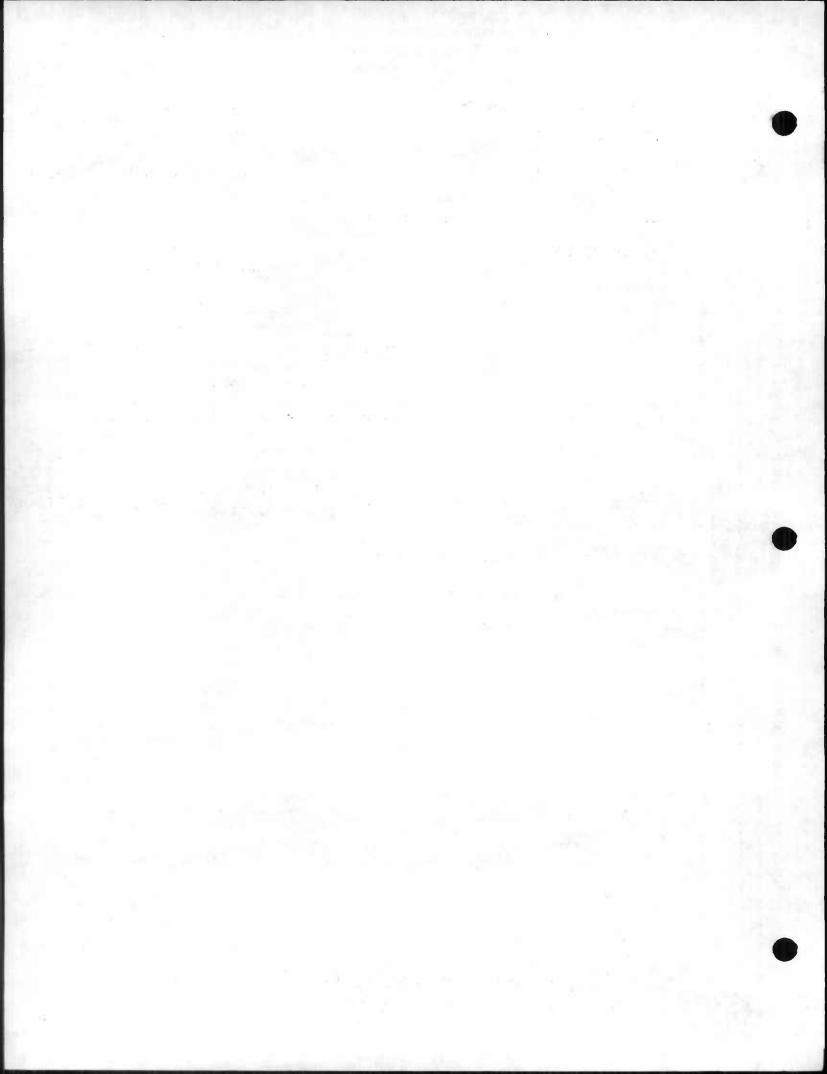
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ral tor	L	Social Security N 216-18-3	089		7. Age (In yrs	s. last birthday) Yrs.		er 1 Year S Days	TOWS	4 Hrs.	8. Date of Bir (Month, De March	th, vear)1922 28, 1902	9. Birthplac Country Mary	e ce (Stata or Foraig y Land
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 1999 Month 5:30am **Physician** HERBERT DANIEL LACHNER OCT. 6, /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1010 EVANS WAY BALTIMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Months 92 212-10-5743 Yrs **Director** 1907 APR. 27, Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director MD. BALTIMORE 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? with 1010 EVANS WAY 21205 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Meritel Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natural", or then any Injury or other traumetic event. In a healtest. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) BALTIMORE CITY SANITATION 6ТН 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UKN. ANNA UKN. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 EVANS WAY BALTIMORE, MD. 21205 MARGARET OBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Dorfa ion 5 ☐ Other (Specify) SACRED HEART OF JESUS10/8/99 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, defined failure. List only one cause on each line. MD. 21224 Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Depressum physicien and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): homer's Box 68760 Physician/Medical Due to (or es e consequence of): 818 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P. within 24 hours after deeth.
To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? Certification: After 1 Neturel 5 Pending 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29e. Certifier edical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MY 101 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swith M 1005 31. Dete filed (Month Day, Yea

State Registrar

32. Registrar's Cipulature



State of Maryland / Department of Health and Mental Hygiene

					Certific	cate of	Death		Reg. No.		01002
		1. Decedent's Nama (First, Middla, La.	st)					2. Data of De Month	ath Day	Yaar	3. Tima of Death
	Physician /Medical	ELIZABETH G. LIT	TLE						er 4, 19		6:35 p.m.
	Examiner	4a Facility Nama (If not Institution, give)			4b. City, Town, or				
		Mariner Health of	f Forest	Hill			Forest H	i11	Harfo	ord	
	Funeral	5. Social Security Number 6. S		ge (In yrs. last birl	Mor	Inder 1 Year	If Undar 24 Hrs. Hours Min.	8. Data of Bird (Month, Da	th v. Year)	9. Birth	place (Stata or Foraign
	Director	213-10-7203	□M 2√F 7	7	Yrs.	54,0	100.0	April	13, 1922		ryland
	pu &	Usual Rasidence of Decedent 10a. Stata 10b. County		10c. City, Towr	or Location					1	10d. Insida City Limits
	aho a										1 Vas 2 No
	or 28a-f a be notified	Maryland Harford	<u>d</u>	Bel A:		(TI- 0-d-			40. 000 1 141	17 . 0	Λ
	di di			O.D.	10	f. Zip Code 21014			10g. Citizan of V	vnat Cou	intry?
	atter death with the Merylen or items 23a or 28s-f show miner must be notified at Funeral Director	110 Idlewild Str	12. Was Deceden		12 Wee C		Hispania Opinina (C	posity Vac or No	U.S.A.	e - Ameri	can Indian,
	5 5 5	1 Never Married 2 Married	Armed Forces	?	If Yas,	specify Cut	Hispanic Origin? (S pan, Mexican, Puari	o Rican, atc.)	Blac	k, Whita,	
20			If Yas, Give		1 □ Y	as 2∭ No	Specify:		Specify	. Wh:	ite
21215-0020	"neturel",	15. Decedent's Ed		16a	Decedent's	Usual Occu	pation		16b. Kind of Bu		
715		(Specify only highest gra	de completed)		(Give kind o lifa. DO NO	of work done OT use retire	during most of world)	king			
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Maryland		John Glenn					Mary Ra	h1			
any	should and Mer umarke umarke	19a. Informant's Name/Ralationship (Type, Print)	t9b.	Mailing Add	dress (Stree	t and Number or Ru	ıral Routa Numbi	er, City or Town,	Steta, Zi	p Code)
	ヒコペト	William D. Little	e (Husban	d) 1:	10 Id1	_ewild	Street,	Apt.2B,	Bel Air	, MI	21014
ore		20a. Mathod of Disposition		20b. Place of cemeter	Disposition	(Nama of	ice)	Data	20c. Location -	City or T	own, Stata
E	TH: H	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1			Church Cen	10/9/99	Hvdes.	Mar	vland
Baltimore,	교 든 돈 중	21. Signature of Funaral Service Licen	see		22. Nam	na and Addr	ass of Facility				
Ö	Depa Impo any I	mars T. Zav	10mas				Funeral				
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	Physician	shock, or heart failura. List only	ona cause on aach	line.						1	Intarval Between Onsat and Death
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o,	an an an inial-t	Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury									
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	es that the death certigned by the attending be detached for use a by Physician/M	Part II. Other significant conditions or	ontributing to death	but not resulting in	the underly	ing causa gi	iven in Part I.	23b. Dld	tobacco uae cor	ntribute 1	to the cause of death?
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Records,	been si should ieted	h	to .	V					an eutopsy	81	Vere eutopsy findings vailabla prior to
ec c	¥ 20 0	raptona	viene	-						of	ompletion of causa f death?
T.	The law requir cate hes been s page 2 should Completed							10	Yas 2 No	1	□ Yas 2□NO
Vital	certificate hes rector, page 2	25. Was casa refarred to medical					26. Place of Dec	oth (Check only o	one)		
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Division of	ding Phy h. After thi funeral	27. Manner of Death 1 ☑ Neturat 5 ☐ Pending	28a. Date of Inj		ima of njury	28c. Inju	iry at	28d. Dascribe I	how injury occur	red	
Ö	tal or Attanding P rs after death. el Director: After ti led in by the funera Certification:	2 Accident invastigation			М	1	Yas 2 □ No				
ž	or Attandated after death Director:	3 Suicide 6 Could not be detarmined	200. Place of Ir	jury - At homa, fai	m, street, fa	ctory, office		28f. Location (S City or Tox	Street end Numb wn, Stata)	er or Rur	ral Routa Number,
	Ce least			,							
	To the Hospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com	29a. Certifier 12 Certifying Phy	ysician: To the best liner: On the basis	of my knowledge,	death occu	rred at tha t	ime, data and place	, and dua to tha	cause(s) and ma	inner as	stated.
	the Figure F	one)	and manner s	tated.	zoi wivosiigi						
	To with	29b. Signatura and titla of certifier				29c. Lican	sa number		29d. Date signe		
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	State	31. Data filed (Month, Day, Year)	.82. Regist	rar's Signature	1		1				
	Registrar	OCT 8 1999	1-1	p.	1000	uks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9 5 5 8 3

				Certificate of	Death	Re	g. No.	01000
1	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last) Auth 4a. Facility Neme (If not institution, give street and number)		4b. City, Town, or Lo	2. Date of Deeth Month	-	3. Time of Death 7:27 A1
-	Funeral		Manor Care 5. Social Security Number 6. Sex 7. Age (In yrs. lest birth	hday) If Under 1 Year Months Days		8. Date of Birth	Balti (9. Bi	
	Director		219-10-7745 1	rs.	NVIIII,	AUG 5,	1924 Ma	rthplace (State or Foreign Fyland 1911) and
	the Mary 28a-f sho	Director	MD N/A Ba	altimore		10	0.00	1√2 Yes 2□ No
	eath with	Funeral Di	2908 East Baltimore St. 11. Marital Status 12. Was Decedent Ever In U.S.	21	224		USA	
020	72 hours efter death with the Maryland natural", or items 23a or 28a-f show dissa Examiner must be notified at	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes Give Year or Dates:	13. Was Decedent of If Yes, specify Cub		Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0020	S 1 3	Completed	(Specity only highest grade completed) Elementary/Secondary (0-12) Coilege (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation a during most of works ad)	ng 1	6b. Kind of Business	
121	filed with Hygiene. ort, the	Con	12 Ho	omemaker			Own H	ome
Maryland	should be filed and Mental Hygi I marked other umatic event, I	To Be	17. Father's Neme (First, Middle, Last) Columbus Beck		18. Mother's Name Cat		Einerse	n
Nar	2 sh and ia m			Mailing Address (Stree	t and Number or Rura	I Route Number,	City or Town, State,	Zip Code)
altimore, I	8 = 5		20a. Method of Disposition 1 Buriai Cremation 3 Demoval from State 20b. Place of Commetery,	908 East Disposition (Name of or, crematory or other place) Crematory,	aca)	Date 2	B <mark>altimor</mark> Oc.Location-City o Baltimor	
Balt	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Listensee 11. Dome S. Gree G. Green Complications that caused the death. Do no shock, or heart failure. List only one ceuse on each line.	22. Name and Address Cremat 9 Fr	ion Soci	ety of	Marylan	d, Inc.
ı	Physician /Medical		shock, or heart failure. List only one ceuse on each line. Immediate Cause (Final disease or condition	ot enter the mode of dyl	ing, such as cardiac o	r respiratory arres	st,	Approximete Intervel Between Onset and Death
	Examiner	ner	resulting in death) Due to (or as a co				o cerbina	8-10 hr
68760,	rificete be executed ng physician and sas the buriel-transit	Medicai Examiner	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	onsequence of):	ndion	Maba	thy.	un-Knasn Dwetian
Вох 68		Physician/Med	resulting In death) Lest					1
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S, P.	v requires that the death ce been signed by the ettendit should be detached for use	by	Renol impliciona	9 Typ	LEIDM	1 Tes	8 2 No 3 F	
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Division of Vital Records,	At the Hospital or Attending Physician: The k within 24 burs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death 28a. Date of Injury 28b. Tin	me of jury 28c. Inju	Nursing Hor	ne 5 LI Residen 28d. Describe hov	nce 8 □Other (Spe v injury occurred	ecify)
Divis	vital or Atteurs after de rai Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Piaca of Injury - At home, farm building, etc. (Specify)			City or Town,		
	o the Hospital	Medical	29a. Certifier (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/one) 2 ☐ Medical Examiner: And menner stated.	or investigation, in my o	opinion, death occurre	ed at the time, det	e and piece, and du	e to the cause(s)
	\$ 1 × 10		29b. Signature and title of certifier MD	D-	-38754	1 290	d. Date signed (Mon	in, Day, Year) - 99
/	O H		30. Name and address of person who completed cause of death (Item 23e) (Ty MALIKA WASEAM., 404	ype, Print) BAST	-ERN A	LVD,	MD-	21221.
	Sta Registr		31. Dete filed (Month, Day, Year) 32. Registrar's Signature	1 .				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death OCTOBER 6, 1999 **Physician** ETHEL LEVIN 4:30 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6210 PARK HEIGHTS AVENUE #307 BALTIMORE N/A H Under 1 Year H Under 24 Hrs. 8. Data of Birth Months Days Hours Min. Max 23, 1914 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 □ M 2X F Months 217-58-5957 85 Director **Usual Residence of Decedent** the Maryland pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hyglans. Important: if Item 27 is marked other than "naturel", or frame 23s or 28s-f show any injury or other traumatic event, the Medical Examination and any and 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6210 PARK HEIGHTS AVENUE #307 21215 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY MEDICAL OFFICE 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) 89 SOLOMON MONEN ROSE NELSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurat Routa Number, City or Town, State, Zip Code) DR. MANUEL LEVIN / HUSBAND 6210 PARK HEIGHTS AVE. #307 - BALTIMORE, MD 21215 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 10/7/99 BOBROISKER BENEFICIAL ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, use on each line. Approximata Interval Between Physician /Medical Immediata Cause (Finat disease or condition resulting in death) Examiner Physician/Medical Examiner attending physician end for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury P.O. Box 68760 that initiated events resulting in death) Last Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not rasulting in tha underlying causa given in Part It. been signed by the should be detached Yes 2□ No 3□ Probably 4□ Unknown Division of Vital Records, PY 24b. Wara autopsy tindings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? has 1 Yes 1 Yas After this certificate To the Hospital or Attending Physicien: within 24 hours effector; Affer this carifica completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify)
Injury at 28d. Delicribe how injury occurred Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? edical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, daeth occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to tha cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053850 back 77 Linden AL person who completed cause of death (Item 23a) (Type, Print) 74 even 31. Date filed (Month, Day, Year)

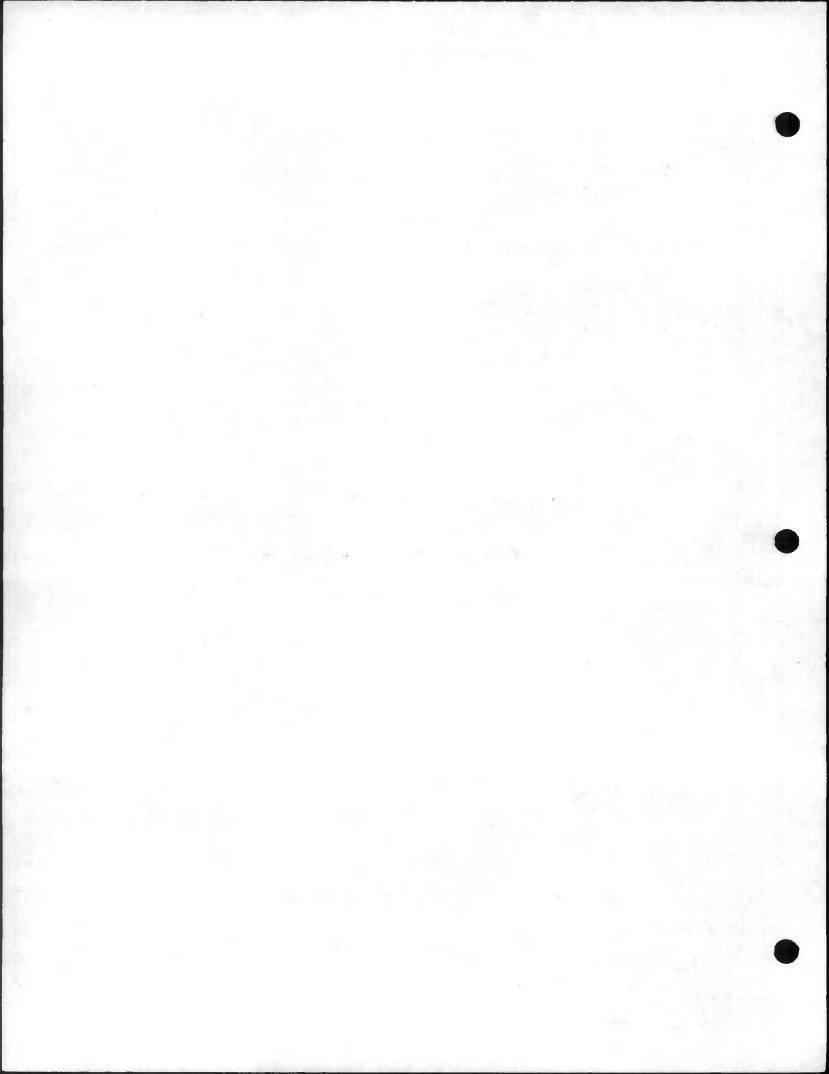
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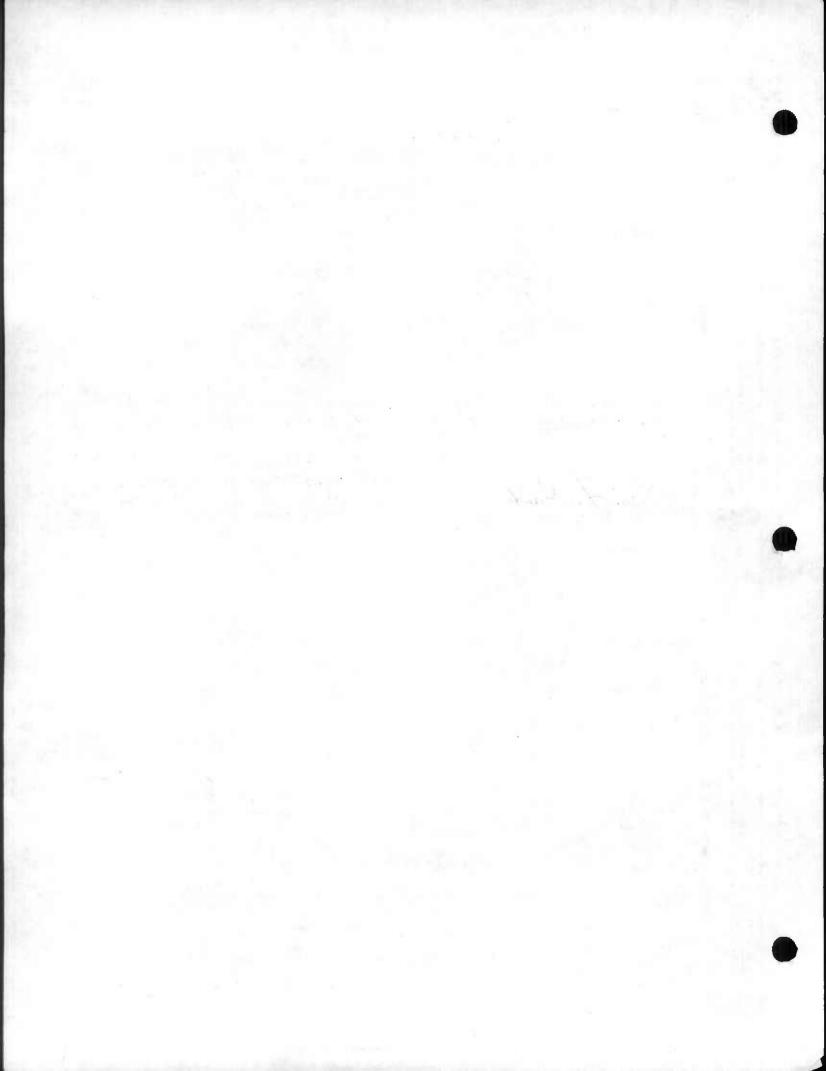


Karen Patricia

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State of Maryland / Department of Health and Mental Hygiene 00000

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BeC	17. Father's Name	(First, Middle, Last)				18. Mother's Na	ame (First, Middle,								
ToB	Victor	G. Mathu	rin			Patricia M. Mack									
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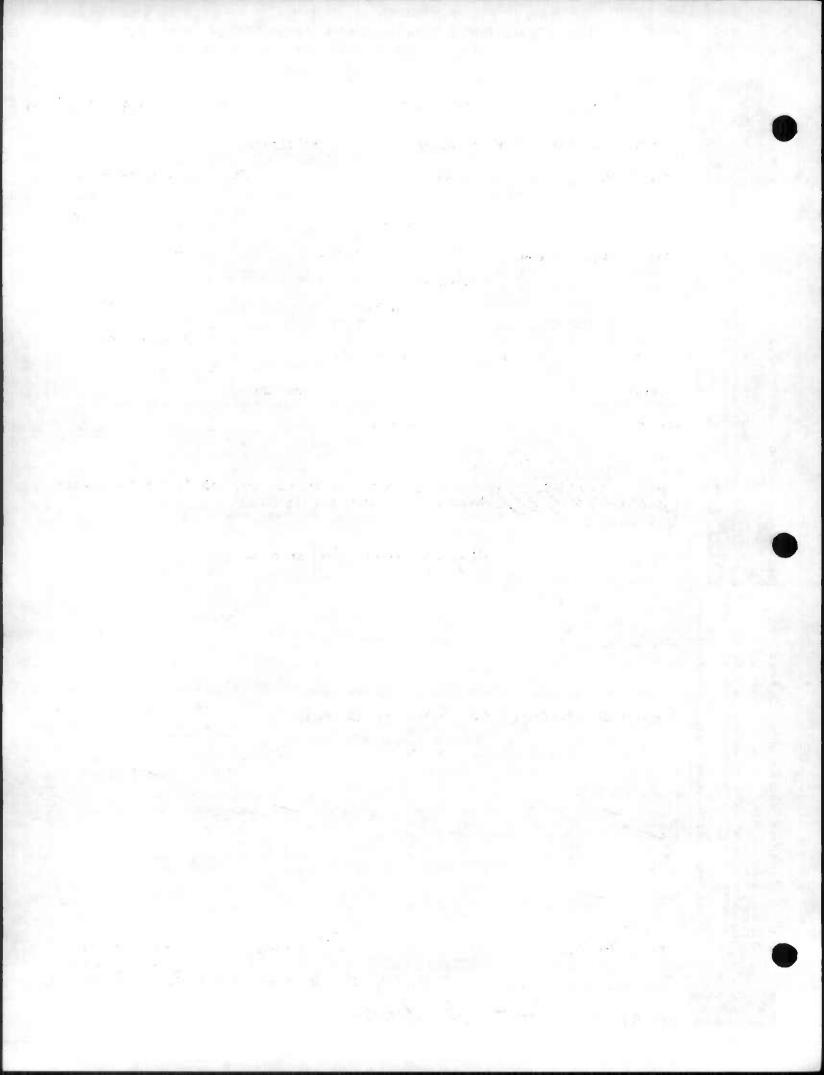
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State Registrar

31. Dete filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Amend	ed Item#20b perFH G776 10/08/99 EW Certificate of Death	Reg. No. 99 3 587
Physician	1. December 1. Name (First, Middle, Last)	2. Dete of Death Month Day Year OCTOBER, 4, 1999 3. Time of Death 1402
/Medical Examiner	4a Facility Name (4 pot institution, give street and number) 4b. City, Town, C	or Location of Death 4c. County of Death
Funeral	5. Social Security Number Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	J. Dittiplaco (Dioto of 7 oraign
Director	213.76.0591 IDM 201F Hours Mi	January 19,1958 MD
deeth with the Maryland ms 23s or 28s-f show rmant be notified at	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 □ Yes 2 □ No
or 28a-f show be notified at Director	10e. Street and Number	10g. Citizen of What Country?
23a or		6 USA
or heme 23 mines man	11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 Yes, Give 1 Yes, Specify:	Aldida.
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	Stepter L. Morris Be	ortha M. Morris
4.0	19a. Informant's Name/Relationship (Type, Print) MO WW 19b. Mailing Address (Street and Number or	Rural Routa Number, City or Town, State, Zip Code)
	20a. Method of Disposition 20b. Place of Disposition (Water of counstiny, cremetory of other place)	Date 20c. Location - City or Town, Stata
injury o	4 Donation 5 Other (Specify)	1999 Baltimore, M
Important: If eny Injury or pnos	21. Signature of Funeral Service Licensee	in typical Home 19
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respiratory arrest, Approximete Intervel Batween
sician edical	Immediate Cause (Finet Pul / Monage & English Sm	Onset end Death
miner	disease or condition resulting in death) a. Dua to (or as e consequence of):	7 / 7
burlei-transit	b. Meumo eystis Carinii p	reuruman 3nhs
	Cause (Disease or injury	a Syndrome Buhs.
e the	that initiated events resulting in death) Last	
ed by the ettendin deteched for use Physician/M	d.	
by the teched	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
2 2		24b Ware subpay fieldings
page 2 should to Completed		24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Comp		1 Yes 2 No 1 Yes 2 No
director, peg	examiner? Hospital: Other	Death (Check only one)
6-	1 Yes 2 No Nospital: 1 Inpatient 2 TER/Outpatient 3 DOA Outlet: 4 Nursing 27. Manney of Death 28a. Data of Injury 28b. Time of 28c. Injury at Work?	g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
ol Director: After the led in by the funeral Certification:	2 Accident investigation M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number,
od in	4 ☐ Homicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	City or Town, Steta)
To the Funeral Direction completely filled in Medical Cert	29a. Certifier (Check only one) Check only one) Check only one) Check only cone) Check only cone) Check only cone)	ice, and due to the cause(s) and mannar es stated. ccurred et tha time, date end place, and due to the cause(s)
Somple Somple	29b. Signature and title of certifier / 29c, License number	29d. Date signed (Month, Day, Year)
6	► Blewel # 1985 mis 038543	Ectober 4, 1999
1)	30. Plame and address of person who completed cause of death (Item 23a) (Type, Print) KANA H. Scange; and 900 Cg, from Avenue Pour	Catober 4, 1999 14 more, Mary land 21229
State	31. Data filed (Month, Day, Year) 32. Registrar's Signeture	
Registrar	OCT 8 1999 June D. sparks	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decement's Name (First, Middle, Last Physician /Medical 4b/City, Yown or Location of Death Examiner 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) if Under **Funeral** 10M 20F Director 10d. Inside City Limits 10a Steti 10b. County 10c. City. Town or Location 'netural', or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funerai Wes Decedent Ever in U.S. Armed Forces! 1 ☐ Yes 2 D No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired). 15. Decedent's Education (Specify only highest grade completed) permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Meiling Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 2 2 07 20b. Place of Dispo 20e. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removet from State 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licenses mo1 23a Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** VENTRICULAR /Medical Immediete Cause (Final SUDDEN disease or condition resulting in deeth) Examiner CARS Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest P.O. Box 68760, Physiclan/Medicai Due to (or es a consequence of): the Pert tt. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 000 VASCULAR_ 3 Probably 4 Unknown Records, Š 24b. Were autopsy findings evailable prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? 2 No 1 Yes 2 No Division of Vital Mospital or Attending Physician: 124 hours after death. Funeral Director: After this certifical letely filled in by the funerel director, p. 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. Con the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi

State Registrar

31. Date filed (Month, Day, Year)

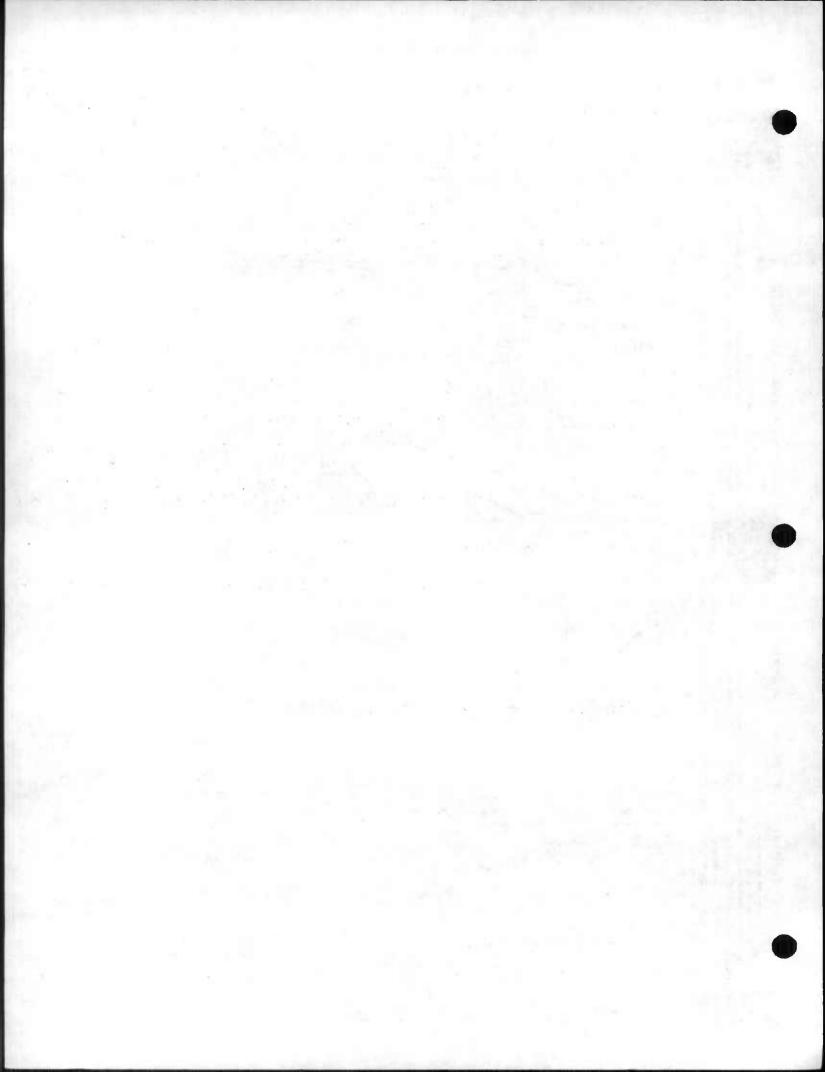
(Check only one) 29b. Signature and title of

32. Registrar's Signature

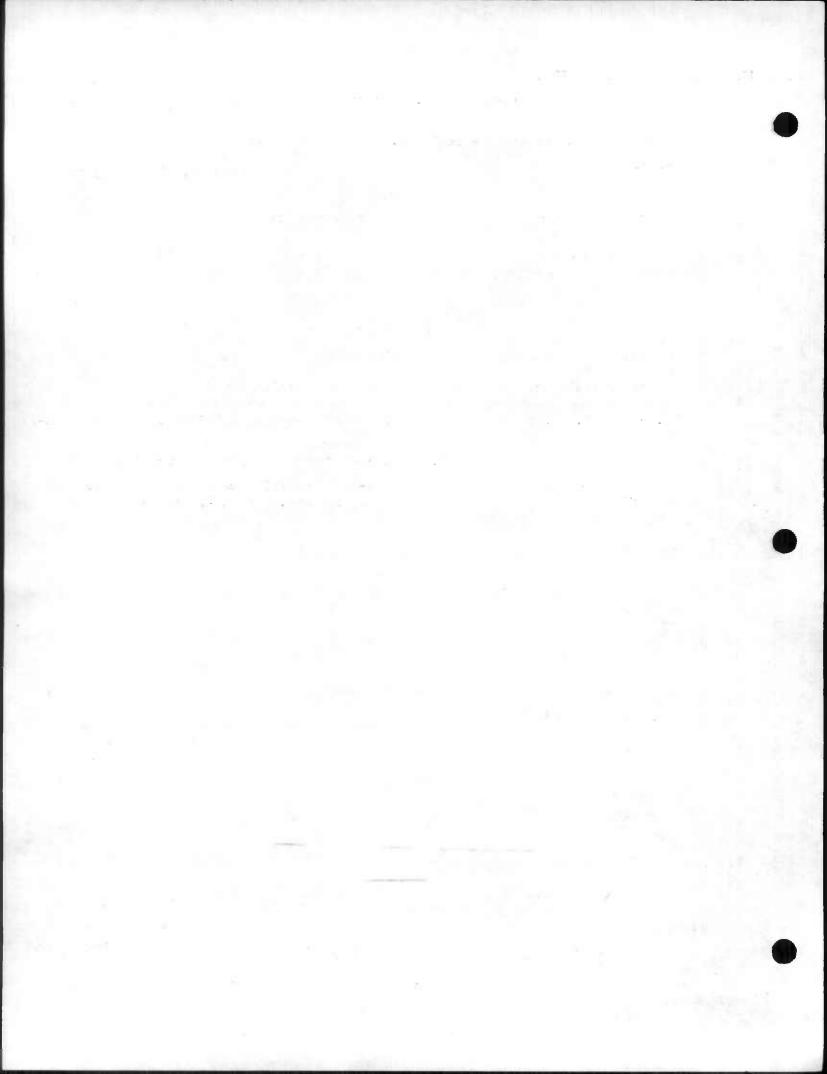
completed cause of death (Item 23a) (Type Print)

29c. License number

29d. Clate signed (Month, Day, Year)



#28a	28b28c, 28e PFR MD G776 10/08/99 AH Certificate of Death 1. Decedent's Nama (First, Middla, Last)	2. Data of D	Reg. No.		3. Tima of Death
ician dical	Marcella K. Minor	Month Octob	er 5, 19	Year 99	3:35PM
er	4a Facility Nama (If not institution, give street and number) 4b. City, Town	, or Location of Dec	ath 4c. County		
,	Coming the prizate Day . Low 110 the control of the	imore Cit	an a	N/A	
	219-30-2865 1UM 2125F 65 Yrs.	Min. (Month, I	25, 1934		aca <i>(St</i> ata or Fora ry) yland
	Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location			100	od. Inside City Lim
	Maryland N/A Baltimore Ci	+			XXYas 2□I
	10e. Street and Number 10f. Zip Coda	Ly	10g. Citizen of N	What Count	trv?
	6602 P113 - 7		Unite		
	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yas or N	lo- 14. Rac	e - Amarica	an Indian,
	Armed Forces? 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 ② No If Yas, specify Cuban, Maxican, F 1 ☐ Yes 2 ② No If Yas, Giva 1 ☐ Yas 2 ☒ No Specify: Year or Dates:	ruano Hican, atc.)	Specify	ok, Whita, a /: Wh	ite
	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Giva kind of work dona during most of	Lundina	16b. Kind of B		
	(Specify only highest grade completed) (Giva kind of work dona during most of lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	working			
	10 Years Homemaker			Home	
		Nama (First, Midd	a, Ma <i>iden Suma</i> n	na)	
		len Siwki	h 0':	On . T	On do l
	Mr. Robert L. Minor 19b. Meiling Address (Street and Number of 6603 Danville Aver				
	20a. Mathod of Disposition 20b. Place of Disposition (Nama of	Data	20c. Location	-	
	P☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata cematary, cramatory or other placa)		100		
	4 Donation 5 Other (Specify) St. Stanislaus Cemeters 21. Signature of Funarel Service Louise 22. Nama and Addrass of Fecility	7 10/8/99	Dunda	lk, M	aryland
	Duda-Ruck Funera	al Home o	f Dundal	k, In	c.
	7922 Wise Ave. 23a. Part 1. Onter the disease, or complications thet caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	Dundalk	, Maryla:	nd 2	1222 Approximata
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	SEASE			
	that initiated events rasulting in death) Last Dua to (or as a consequence of): d				
	Part II. Other significant conditions confributing to death but not resulting in the underlying causa given in Part I.	23b. DI	d tobacco uee co	ntribute to	the cause of dea
	Dianetes Mellitus Peripheral Vascular Disease	1[Yes 2 No	3DX Prob	ably 4 Unkn
	Peripheral Vascular Disease		es en autopsy formed?	svs	re eutopsy finding illable prior to npletion of cause lesth?
l		10	Yas 2 No	10	Yas 200 No
	axaminar/	Deeth (Check only	/ one)		
		ng Homa 5 ☐ Ra)
	1 Netural 5 Pending (Month, Day Year) Injury Work?	ZOG. Describ	B how injury occur	. 30	
	2 □ Accident 3 □ Suicide 4 □ Homicide Accident Invastigation Suicide Could not be detarmined Could not be deta		(Street and Numb own, Stata)	per or Rural	Routa Number,
	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end process of axamination and/or invastigation, in my opinion, death and manner stated.	plece, end due to the coccurred at the time	e causa(s) end me e, date and piece,	ennar as sta and dua to	ated. tha causa(s)
	29b. Signatura and titla of commer 29c. License number		29d. Data signe	d (Month, L	Day, Year)
	D44100		OCTOBE	2 ctt	1999
	30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)) 111
	31. Data filed (Month, Day, Year) OCT 8 1999 32. Registrar's Signatura G. Sparks	aryland	1, 212	ZE.	
•	31. Data filed (Month, Day, Year) 33. Registrar's Signatura 4				
	OCT 8 1999 (3)				



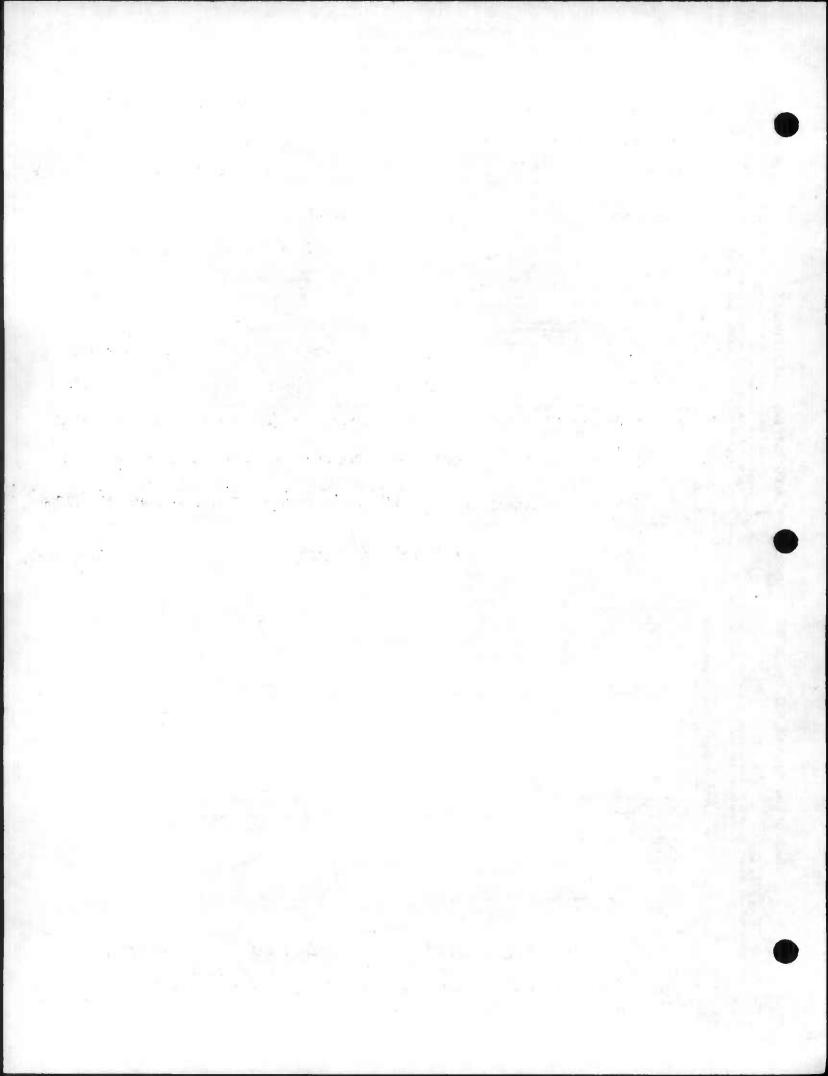
State of Maryland / Department of Health and Mental Hygiene

1.	Decedent's Name (First, Middle, L	ast)		Cer	tificate o	Dean		2. Dete of Deat	ng. No.	.0	3. Time of Death
ician	Eleanor	В.		Mi	rasky			Month Octobe	Day 10	Year 199	9:45 PM
niner 4a	Facility Name (If not institution, g)		200.17	4b. City, 1	Town, or Loc	cation of Death	4c. County		7.45 111
liei	3401 E. Norther	n Parkway				Ва	ltimo	re			n/a
			ge (In yrs. las 71	t birthday) Yrs.	If Under 1 Yes Months Dey		er 24 Hrs. Min.	8. Date of Birth (Month, Day, NOV • 12	Year) 1927	9. Birthp	place (State or Foreign necticut
Us	suel Residence of Decedent le. State 10b. County		10c. City, 1	Town or Loc	cation						Od. Inside City Limits
oto 1		/a			Ba	ltimo	re				¥ Yes 2 No
Funeral Director	e. Street and Number 3401 E. Norther	n Parkway			10f. Zip Code	212	206	10	og. Citizen of V Unite		
P V	. Merital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forcas' 1 Yes 20 If Yes, Give Year or Dates:	?	It	Vas Decedent of Yes, specify Cu	iban, Mexic	an, Puerto P	cify Yes or No- Rican, etc.)		k, White,	an Indian, etc. White
	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or		(Give I	ent's Usuel Occ kind of work don OO NOT use reti	e during mored)	ost of workin)g	16b. Kind of Bu		dustry estic
	. Father's Name (First, Middle, Las	a)			Homen		hara Nama	(First, Middle, N	In idea Compan		estic
9 0 1/	Joseph	()	Borg	mine			lary	(FIIST, MIDDIÐ, K	naloen Sumam	•	assini
	Da. Informant's Name/Relationship Nalter Mirasky /				g Address (Stre						
-	a. Method of Disposition 1 Burial 2 ACremetion 3 4 Donation 5 Other (Special Control of Control o	☐Removet from Stete	cem	e of Dispos etery, crem	sition (Name of petory or other p ant Cren	lece)		Dete 2	20c. Location - Balti	City or To	wn, State
21	Signeture of Funerel Service Lice		10100	22.	Name and Add	ress of Fed	ility				
	Topley to	Kuman	un	87	717 Gree	n Pas	stures	Dr., B	altimor	e, M	
	3a. Pert1. Enter the disease, or conshock, or heart tellure. List only	npications that cause y one cause on each t	d the deeth.	Do not ente	or the mode of d	ying, such e	es cardiac of	r respiretory erro	est,	1	Approximate Interval Between Onset and Deeth
di re	sease or condition sulting in death)	θ	Due to (or e	s e conseq	uence of):		,			1	Zgear
I Examiner	equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury	b	Due to (or es	s a consequ	uence of):				P-		
th.	at initiated events sulting in death) Last	d	Due lo (or as	a consequ	ience of):						
								1			
Pa	rt II. Other significant conditions	contributing to death t	out nat <i>re</i> sultir	ng in the un	derlying cause	given in Per	t I.	23b. Did to			the cause of death' bebly 4 Unknow
Completed by								24a. Wes a		800	ere eutopsy tindings allable prior to mpletion of cause
5								1 □ Ye	s 2 1 No		death? ☐ Yes 2☐ No
	. Was case referred to medical					26. Pla	ice of Deeth	(Check only on	G		
0	examiner?	Hospitel:	ent 2 ER	VOutpatient	3□ DOA	ther:		ne 5 R Reside		er (Specif	ý)
	Manper of Death Naturat Accident Manper of Death Pending investigation		ary 28 ay Year)	b. Time of Injury		jury at ork? ☐ Yes 2[8d. Describe ho	w injury occur	red	
	3 Suicide 6 Could not determine	286. Place of in	jury - At home lc. <i>(Specify)</i>	e, term, stre	et, tectory, offic	a	2	81. Location (St City or Town		er or Rura	I Route Number,
	le. Certifier (Check only one) Certifying P	hysician: To the best miner: On the basis of and manner st	of examinetion	dge, death and/or inv	occurred et the estigetion, in my	time, date o	end place, e eeth occurre	nd due to the ca d at the time, da	use(s) end ma ate and place,	nner as st and due to	tated. the cause(s)
	b. Signeture and title of certifies/	A			29c. Lice	nse numbe	r	2	9d. Date signe	d (Month,	Day, Year)
	rand (1)	low	W	1		050	528		161	18/81	
30	Nau Plane	completed cause of	death (Item 23	Ba) (Type, F	Chail	6 5	+ F	BACF	mo	212	264
	Date filed (Month, Day, Year)	1	rar's Signature	-			. /-				

Mes

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death October PAUL THOMAS MCCAFFREY 7301 6 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Aug. 5, 1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1♥M 2□F Yrs. Pennsylvania 209-22-0155 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 953 Sablewood Road 21014 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Merital Status 1 Yes 2 X No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White. 3 ☐ Widowed 4 🕱 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12th grade College (1-4or 5+) Manager Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas McCaffrey Catherine Tovey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. McCaffrey (Daughter) 8807 Plymouth St., Apt. 2, Silver Springs, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Gardens 10/9/99 Bel Air. MD. 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 21. Signeture of Funeral Service Licensee Bucin 610 W. MacPhail Road, Bel Air, MD 21014 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teiture. List only one cause on each line. Approximete tntervel Between Onset end Death tmmediete Cause (Finel SEPSIS 9 DAYS diseese or condition resulting in deeth) Due to (or as a consequence of): OSTEDMYELITIS Due to (or es a consequence of): Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PERIPHERAL VASCULAR DISONSE Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ N6 3 ☐ Probably 4 ☐ Unknown INSULIN DEPENDENT DIAGRETES CHANIC AGNAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? CARDIOMYOPATHY 1 SCHEMIC 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Tes 2 No

Examiner Box 68760, Physician/Medicel Records, P.O. by Completed Division of Vital Be Certification: or Attending To the Hospital or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fun

Physician

/Medical

Examiner

Direct

Funeral

Funeral

Director

ö

Department of Health and Important: If Item 27 is me

Physician /Medical

Maryland 21215-0020

altimore,

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25. Wes case referred to medical examiner? 1 Yes 28 No 27. Menner of Death 1-WNeturel 2 Accident

6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

OCTOBER 7, 1999

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number

Lew Nowakowski no Do 8096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

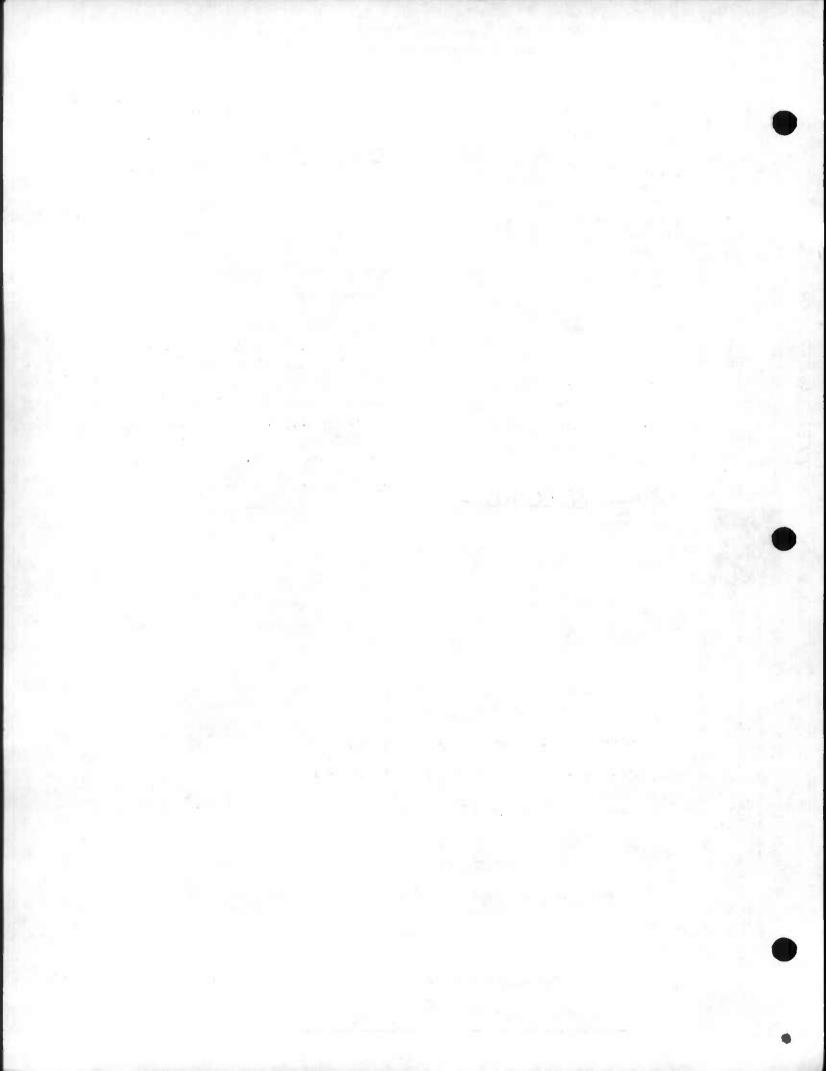
ANDROW NOWAKOWSK W.

MD 125 No MAIN ST. BOLATA, MD 21014

State Registrar

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31. Dete filed (Month, Day, Year) 8 1999 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM # 5 PER FH G777 11/12/99 AH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 0205 Month Vear **Physician** MARGARET. mon DRICK. R. 10 07 99 · /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Woods Nursing Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthplace (Stete or Foreign Country) Funeral Days 1 M 200F Months Hours 84 07 8/1/1915 Director 5862 Pennsylvania Usual Residenca of Deceden the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at MD Baltimore Perry Hall 1 ☐ Yes 2 ☑ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21128 13 Capland Court Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ Z™No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Item any Injury or other traumatic event, the Medical Evantine ones. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Fabric Mill Sewing Machine Operator 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles Stuber Rose Pless1 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lucille A. Snair/ Daughter 13 Caplan Court Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/11/99 Allentown PA. Sacred Heart Cemetery 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility John C. Miller Inc. 2000 ceg 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Sist only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting In death) 15 Days /Medical urosepsis **Examiner** Due to (or es a consequence of) Examiner ettending physician and I for use as the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificete be execu Box 68760 Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contributs to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown melliters Dicebeaches Division of Vital Records. þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy Completed performed? certificate has b lirector, page 2 sl 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel death. 1 Yes 2 No I or Attendi after death Director: A 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homleide Hospital 24 hours 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi edical

State Registrar 31. Date filed (Month, Day, Year) 1999

S. Raguray

Belair

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

(Check only one)

29b. Signature end title of cartifier

32. Registrar's Signature

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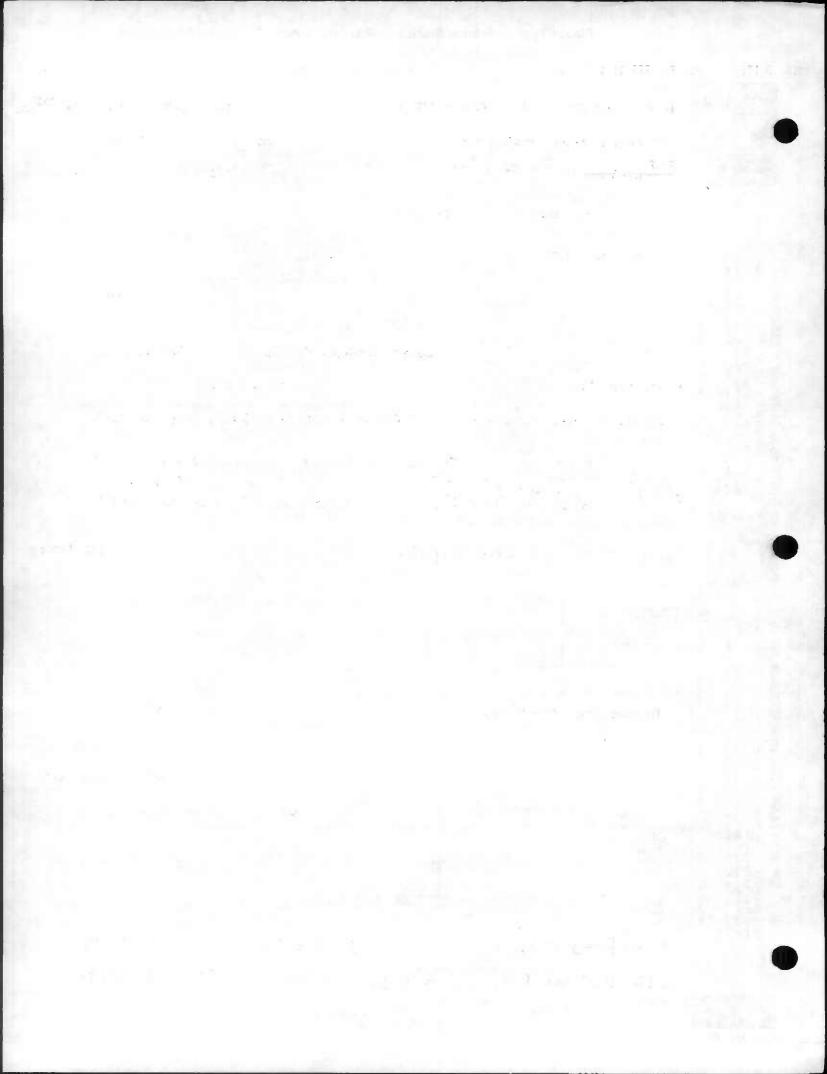
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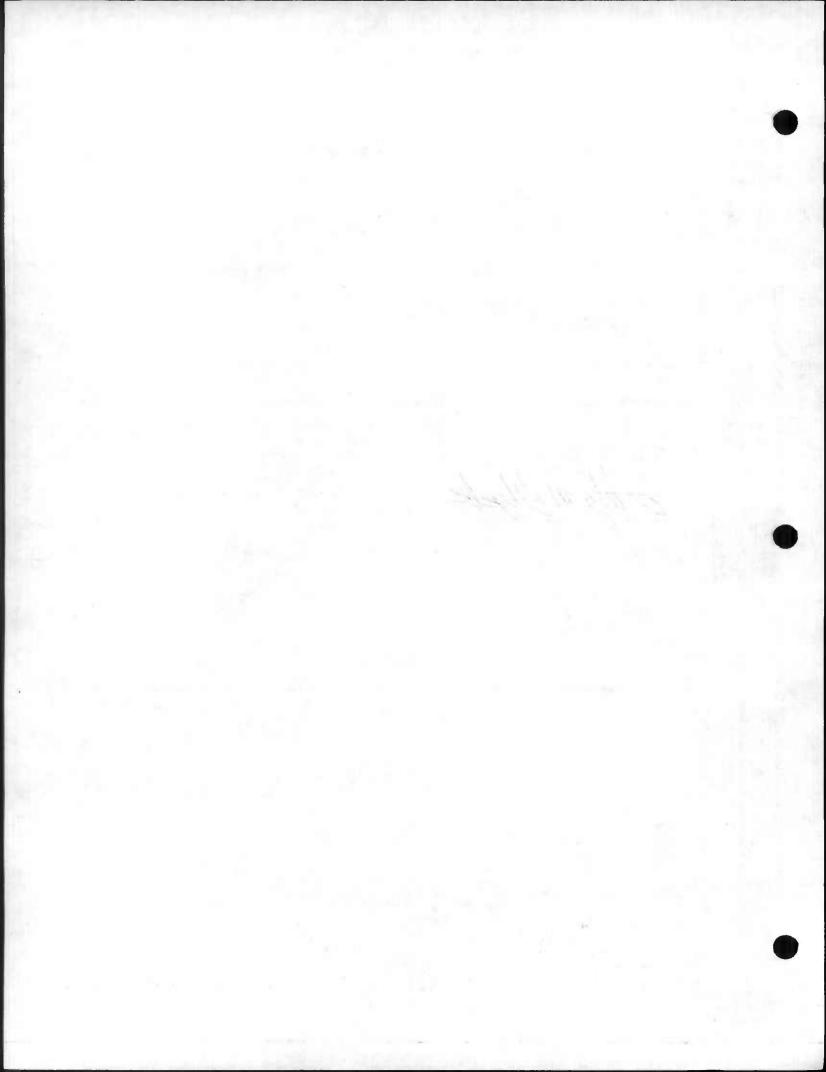
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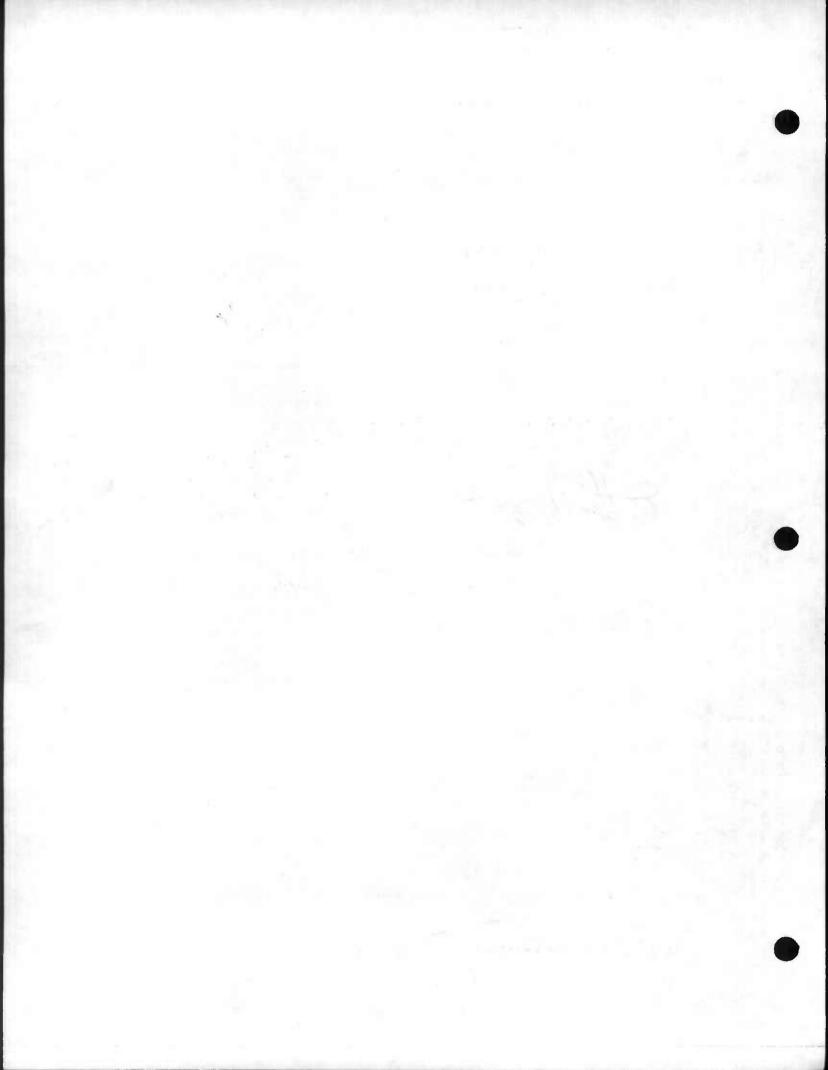
State of Maryland / Department of Health and Mental Hygiene 99 3 5 3

			Certifica	ite of Death		Reg. No.		
Dhuaisian	1. Decedent's Name (First, Middle, La	nst)			2. Date of De	ath Day	Year 3. Time of Death	
Physician /Medical	Walter Richard	(1) 1 1	er 5, 1	199 7:30P	n			
Examiner	46 Charling Many Institution aire short and numbers							
Funeral		are 105 Pita		ler 1 Year If Under 24 Hi		15a	9. Birthplace (State or Forei	ian
Director	209-20-9112	1⊠M 2□F 72	Yrs. Month	s Days Hours Mi	n. (Month, Da	y, Year) er 28, 1	9. Birthplace (State or Forei Country) 926 Pennsylva:	ni.
9	Usual Residence of Decedent							
rns 23s or 28s-f show Emist be notified at neral Director	10a. State 10b. County		ty, Town or Location				10d. Inside City Limit	
Cto Cto	MD Balt:	Imore	Baltimore				1 ☐ Yes 2☐N	10
, or leans 23s or 25s-f show arriver must be notified at by Funeral Director	10e. Street and Number 7528 Kenlea Ave	enue	10f. 2	Tip Code 21236		10g. Citizen of V U.S		
-	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Wes Dec	sedent of Hispanic Origin? secify Cuban, Mexican, Pur	(Specify Yes or No	- 14. Rac	- American Indien,	
F 10 P	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		2 No Specify:	orto rivari, etc.)		k, White, etc. : White	
rt, the Medical	15. Decedent's E (Specify only highest gri	ducation ade completed)	16a. Decedent's Us (Give kind of	vork done during most of w	vorking	16b. Kind of Bu	siness/Industry	
omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Electric	al Engeneer		Light	ing Co.	
Ü	17. Father's Name (First, Middle, Last)			ame (First, Middle,	Maiden Sumam	e)	
e aven	Bronislaus Marc	zak		Helen	n (Unkno	wn)		
traumatic avent, To Be C	19a, Informant's Name/Relationship (Type Printl	19h Mailing Addre	ss (Street and Number or I			State Zin Code)	
trau	Viola Marczak/Wi	***		nlea Avenue			land 21236	
other tr	20a. Method of Disposition	20b. I	Place of Disposition (A	lame of	Date		City or Town, Stete	
	1X Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		rdens of Fa		10/8/99		ore, Maryland	
20 4	21. Signature of Funeral Service Lice			and Address of Fecility				
any injury o		11/1. 1		Belair Road				
	1/ Wy 1/1	HUER						
	23a. Rent. Enter the dispase, or con- shock, or heart failure. List only	one cause on each line.	ii. Do not enter the in	boe of dying, socil es cardi	ac or respiratory e	riest,	Approximate Interval Between Onset and Death	
cian Iical	Immediate Cause /Final	1/ 5	D				0.1	
niner	Immediate Cause (Final disease or condition resulting in death)	· / / 4 Po	xic De	ain In	URY		20 day	S
		Due to (c	or es a consequence o	ŋ:	7 . 0		,	
# E		b						
burletranek Sai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a consequence o	1):				
9	Cause, Enter Underlying Cause (Disease or injury	c						
£ \$	that initiated events resulting in death) Last	Due to (c	r es a consequence o	7):				
2		d						
forus				A				
be detached for us	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	cause given in Pert I.	23b. Did		ntribute to the cause of deat	h?
P date					10	Yes 2 No	3 Probably 4 Unkno	nwr)
					040 1440		24b. Were autopsy tindings	
. paga 2 ahould Completed						an autopsy med?	available prior to completion of cause	,
mpidm							of death?	
E O					10	Yes 2 No	1 ☐ Yes 2 ☐ No	
director, pag	25. Was case referred to medical examiner?			26. Place of D	eath (Check only o	one)		
ု	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	OOA Other: 4 Nursing	Home 5 ☐ Resi	dence 6 Oth	er (Specify)	
	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe	how injury occur	ed	
e funaral	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		М	1 ☐ Yes 2 ☐ No				
Completely filled in by the funantial Medical Certification:	3 Suicide 6 Could not be determined	288. Place of Injury - At h	ome, farm, street, fect	ory, office	28f. Location (: City or Tox		er or Rural Route Number,	
B 5	4 Nomicoe	building, etc. (Specif	y)		City by You	mi, State)		
	29a. Certifier 10 Certifying Pt	ysician: To the best of my kno	wledge, death occurre	d et the time, date and pla	ce, and due to the	cause(s) and me	nner es stated.	
completely filled in by	(Check only 2 Medical Exar	niner: On the basis of examina and manner stated.	tion and/or investigation	on, in my opinion, death oc	curred at the time,	date and place,	and due to the cause(s)	
Me Me	29b. Signature and title of donliner	1401/	2	9c. License number			(Month, Day, Year)	
	\(\) \(MW	R	N86338		2/1	, 5 1999	
	20/Pmp and other at	nomelated agues of death the	220) (T) = (2)	NOODO		rtobe	R 5, 1999 Himore, MD212	
	30 Name and address of defision who	completed cause of death (iter	n 23a) (Type Print)	F 11.	7), R	II. AMDOID	127
	110halldo	INELINO	1.1. 100	Oleanklin -	guare 1	rive Un	Itimore, 141 DX d	11
State	31. Date filed (Month, Day, Year)	32. Fjegistrar's Signa	B. A	rocks	V			



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	1 December 1 Name Wint Middle Leave	44	Certifi	cate of	Death		Reg. No.	31594	
Physician	Decedent's Nama (First, Middla, Last LILLIAN MARI					2. Data of Dec	Day Y	3. Tima of Death	
/Medical	4a Facility Nama (Il not institution, giva			4b, City, Town, or L	10 ocation of Death		9 10:30 PM		
Examiner	108 Edwards Ta		t #52		Ocean (Worcester		
Funeral	5. Social Security Number 6. Se	•	s. last birthday)	Under 1 Yaar	If Under 24 Hrs.	8. Data of Birt (Month, Da)		Birthplaca (Stata or Foreign Country)	
Director	212-18-2096 15 Usual Residence of Decedent	□M 2X0 F 86	Yrs. Mo	onths Days	Hours Min.	10/10	12	MD MD	
death with the Maryland ma 23a or 28a-f ahow rmust be notified at neral Director	10a. Stata 10b. County		City, Town or Locatio					10d. Inside City Limits	
offine Me	MD Worces	ter	Ocean Cit					1 ☐ Yas 🎉 No	
Olr Dir	10e. Street and Number	DD 11		Of. Zip Code	1010		10g. Citizen of Wha	it Country?	
a 23	108 Edwards T	·			1842		USA	Amaricen Indian,	
or he or he	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Dates:	If Yas	s, specify Cub	Hispanic Origin? (Spean, Mexican, Puarto Specify:	Pican, atc.)	Biack, 1	White, atc.	
Maryland 21215-0020 d2 should be filed within 72 hours aft th and Mental Hydlene. 71s marked other than "natural", or traumatic avent, the Medical Exam To Be Completed by F	15. Decedent's Edu	ucation	16a. Decedent's	s Usual Occup	pation		16b. Kind of Busin		
1 21215-0 ed within 72 ho yglene. or than "naturi rt, tre Medical Completed	(Specify only highest grad	(a completed) College (1-4or 5+)	completed) (Giva kind of work dona during mos			king			
d will glene mo	8	College (1-401 54)	Switchb	board Operator			Cab Co		
ind tal Hy went	17. Fathar's Nama (First, Middla, Last)				18. Mothar's Nam	a (First, Middle,	Maiden Sumama)		
yla Neut Ment Ment Ment To	William Albert W	larder			Joseph	ine Skir	nner		
Aar 2 shot and le m	19a. Informant's Name/Raiationship (7)		100000000000000000000000000000000000000		and Number or Ru				
and and mark	William B. Meehli		108 Ec	dwards	Taylor	RD Ocea	n City,	MD 21842	
ges H its H its or ot	20a. Mathod of Disposition 1 Suriai 2 Cramation 3 F	Removal from State	Piace of Disposition cometery, cremator	y or other pla		Data	20c. Location - Cit	- Contract	
timent tant:	4 Donation 5 Other (Specify)		oreland Me					e, Maryland	
Baltimore, Maryland 21215-002 permit. Peges 1 and 2 should be filed within 72 hours Department of Heelih and Mental Hygiene. Important: If fram 27 is married other than "natural", any Injury or other traumatic avent, the Medical Exponse. To Be Completed by	21. Signatura of Funaraly Vice Licens	My le			ir Road B				
	23a. Part T. Enter the capatile, or companion, or heart failure. List only o	lications that caused tha de-	ath. Do not antar the	a moda of dyi	ng, such as cardiac	or raspiratory ar	rast,	Approximata Interval Between	
Physician /Medical Examiner	Immediata Causa (Final disaase or condition rasulting in daath)	BICATE Due to	RAZ 1	Aone	nac.	MAS	5	Onsat and Death	
ě		THORA	(or as a consequence	ce of):	OU.SN	2			
cata be executed physician and s the burial-transit	Sequentially list conditions	0.	(or as a consequence		70,				
68760, ficate be execut physician and is the burial-tran edical Exar	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseasa or Injury								
68760, ificate be exemple of physician as the burial edical Ex	Cause (Diseasa or Injury that initiated evants Dua to (or as a consequence of):								
W = D = W									
Box 6 Box 6 Bath certifi attending for use as		d							
P.O. Box let the death certified by the attending etached for use use.	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobecco use contribute to the cause of death?		
						1	Yee 2□ No 3	Probably 4 Unknown	
cord requir been s should							an autopsy med?	24b. Wara autopsy findings available prior to completion of ceuse of death?	
I Rec The law ate has t page 2 s						101	as 2 No	1 ☐ Yas 2 ☐ No	
of Vital Physicien: The Physicien: The this certificate ral director, page TO Be Co	25. Was cesa rafarrad to medicel				26. Place of Dea			12.163 22.110	
of Vita Physician: this certific ral director, TO Be	axaminer? 1 ☐ Yas 2 ☑ No	Hospital: 1 ☐ Inpatient 21	☐ ER/Outpatient 3	DOA ON	hoc		lence 8 Other	(Specify)	
Vision of Attanding Phy or death. ector: After this by the funeral of iffication: T	27. Manner of Death 1 Natural 5 Panding 2 Accident Invastigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo		_	now injury occurred		
Division of teal or Attanding P is after death. al Director: After ted in by the funers Certification:	3 Suicida 6 Could not be datarmined		28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)				Street and Number on, Stata)	or Rural Routa Number,	
Division or to the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:		elcian: To the best of my kr ner: On tha basis of axamir and mannar stated.							
To the comp	29b. Signature and title of certifier	1		29c. Licens	se number	1	29d. Date signed (fonth, Day, Year)	
	C Toluan	and		D4	625 T		10/4	4/29	
	30. Name and address of person who co	omplated causa of death (Ite	ern 23a) (Type Print	rlen	6257	2181	/		
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign	natura &	1	,				



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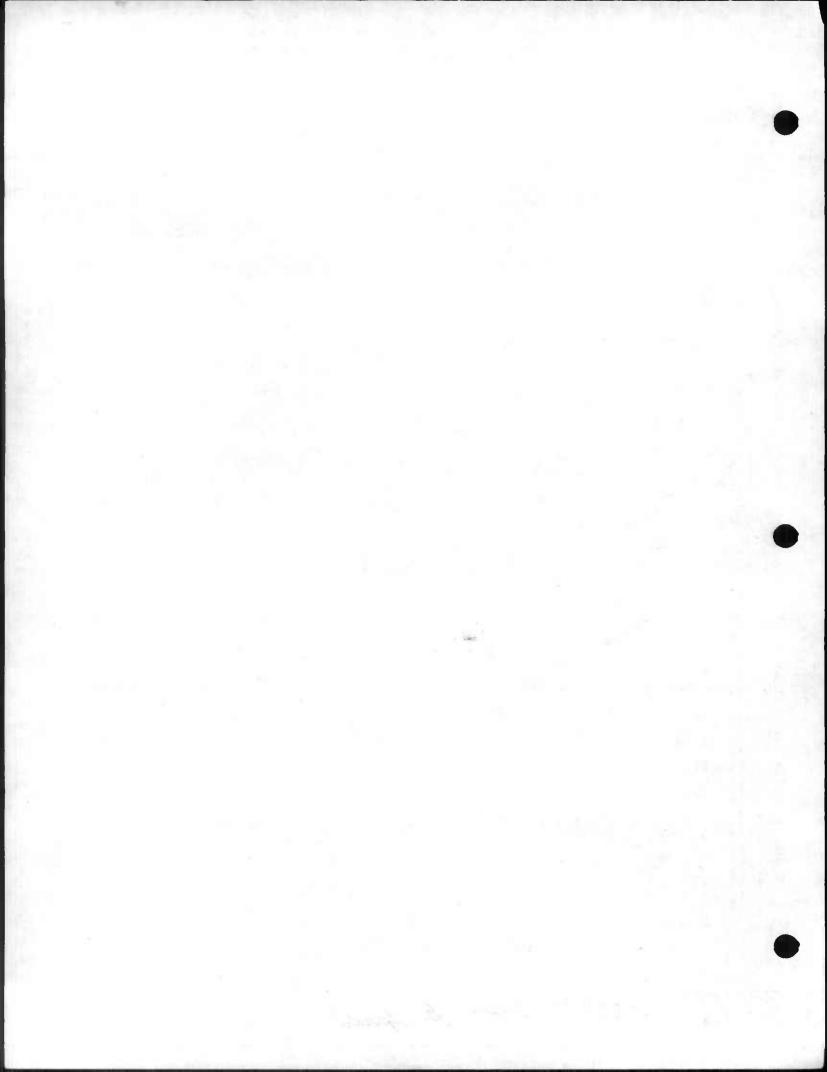
State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Year **Physician** Eloise 02:37 am Nixon 1997 October 6 /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner BAltiMore Hopkins Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 579-68-9156 Usual Residence of Dacedent 1 M 2 Ø F Vrs S. C. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow BAltiMore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itema 23a or Preston U.S. A. 2414 21213 Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Wes Decedant Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 Nevar Marriad 2 Merried 1 Yes 2 No If Yes, Give Year or Datas: altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Black à 3 Nidowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry i Hygiene. College (1-4or 5+) Elementary/Secondery (0-12) 6 12 WORK permit. Pages 1 and 2 should be filed Department of Health end Mentel Hygid Important: If Item 27 is marked other I any Injury or other traumatic avent, III 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be To Lensey Cais Annie Moses 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 2414 E. Reston St. Baltimore, Sonders MACY And 21213 20c. Location - City or Town, State (daughter /ACA 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Forest 21. Signature of Funeral Service Licenson 22. Neme and Address of Fecility Baltimore, MARYland 21213 54. CACOLINE 23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or raspiratory arrest shock, or hear failure. List only one cause on each line. Approximate Intervel Between Onsat and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Sepsis Examiner Dua to (or es e consequence of) Hep-tic Failure attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760 Gastrie Ulcer Physician/Medical Due to (or es a consequence of): Stage Rual DISease Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy Completed 1 Yes 1 Yes 2 No 2 □ No certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case rafarred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To pariant 2□ ER/Outpatient 3□ DOA 28e. Dete of tnjury (Month, Dey Yaer) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Dascribe how injury occurred 5 Pending investigation Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier Clarke, MD 1999 October 6 30. Nama end address of person who completed cause of death (Item 23e) (Type, Print) Clarke 600 North Wolfe Street, Baltimore, MD 21287 0. MD 2. Ragistrar's Signeture 31. Data filed (Month, Dey, Year) State

Registrar

OCT 0 8 1999



Piease Type or Print in Biack Indelibie Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year **Physician** Frieda K. Niebuhr October 6, 1999 10:25 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8117 Cornwall Road Dundalk If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthpiaca (Stete or Foreign Country) **Funeral** Months 1□M 20 F 213-34-0882 Yrs 92 Director Dec. 31,1906 Germany Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes XX No Dundalk Directo Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? matthen 21222 8117 Cornwall Road United States Funeral Heme 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status filed within 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2X No If Yes, Give 8 1 ☐ Yes 2 No Specify: White Specify: þ 3€ Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home Unknown permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: if item 27 is marked others injury or other. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Not Known Karl Kroeger 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8117 Cornwall Road Dundalk, Maryland 21222 Ms. Gerda Niebuhr/Daughter 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Hilltop Service Corp. 10/8/99 Towson, Maryland 21. Signeture of Funerel Service Licansee 22. Name end Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 1 Don 7922 Wise Ave. Dundalk, Maryland 23a. Pert1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel diseese or condition resulting in death) Due to (or as e consequence of): Sacra nfected Decubiti

Physician /Medical Examiner

> and buriel-tran

the

Be Completed by

Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

certificate director.

this funeral

After

s after des.

ne Hospital or Atte n 24 hours after de ne Funeral Directo pletely filled in by th

To the Hosp within 24 hou To the Fune completely fi

Box 68760.

Division of Vital Records, P.O.

altimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequence of) Due to (or es e consequence of)

23b. Did tobacco use contribute to the cause of death?

Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown atrial Fibrillation 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 I Homiclde 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

(Check only one)

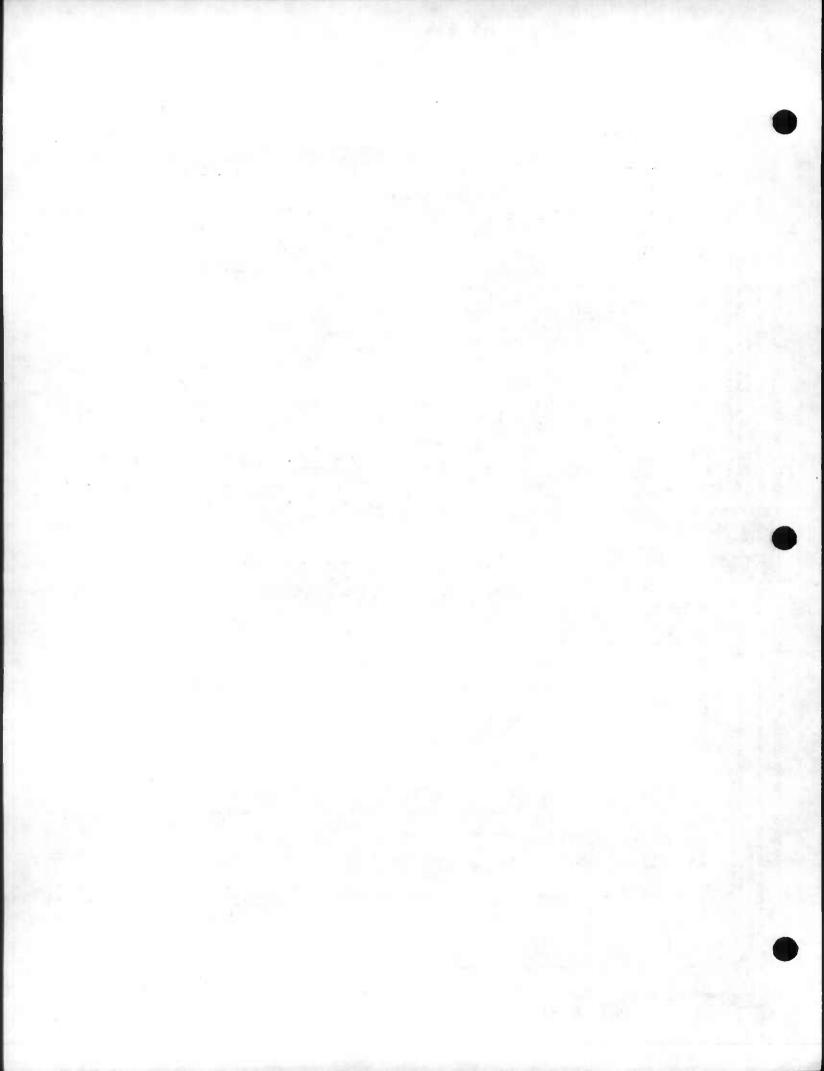
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lystol Sumpson M. D DO054502

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Baltimore MD Hopkins Bayview Circle 32. Registrer's Signeture 31. Dete filed (Month, Day, OCT

State Registrar

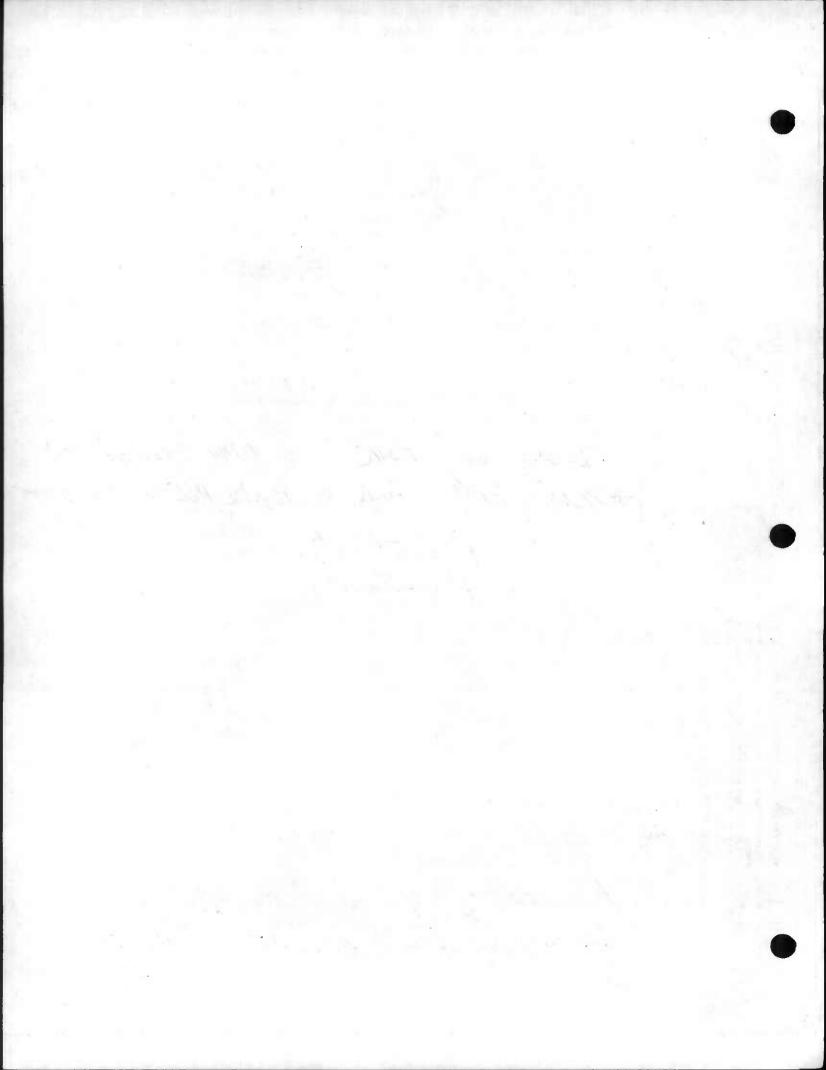


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** PARKER ONEAL 10:00 AM KENDALL SEPT. 3 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. Months Days Yrs. PRINCE GEORGES 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Sex 12M 2DF Director MAR **Usual Residence of Decedent** 10a. State 10c. City, Town or Location 10d. tnside City Limits ahow notified at 1 Tes 2 No PRINCE GEORGES SUITCANO Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be 3703 SILVER PK. OR. 20746 U.S.A. **Нете 23**е Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 212 No Specify. Specify: BUACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within : Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event, ma Median Institution." College (1-4or 5+) Elementery/Secondary (0-12) NONE NONE - INFANT INFANT 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) 8 JERI VERNICE PARKER DANNY DINEAL 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PRINCE GEORGES HOST. CTR. 3001 HOSPITAL ORIVE, CHEVERLY MU 20185 20b. Place of Disposition (Name of cometery—stematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 Burial 2 Cremation 3 Removet from State 4 Donetion 5 LOth Company 22. Name end Address of Facility 23a. Pert / Ender the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock. The property of the cause on each line. Approximate tntervet Between Onset end Deeth **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical Examiner siclan and burial-trensit be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as e consequence of) Box 68760. the attending physician Physician/Medical 4 Due to (or as a consequence of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Records. ò 8 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2₽ No 1 Inpatient edicai Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Meturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the bests of examination endor investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Cartifier 29c. License number 29b. Signature and little of certify 29d. Date signed (Month, Day, Year) 013625 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MO 20785 JONG- LEE, MO- 3001 HOSPITAL ORIUE, 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1999 OCTOBER 07 HARRISON UGH TER 6:50 AM. /Medical 4b. City. Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner HOSPICE BALTIHORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MARCIT 8, 1925 5. Social Security Number 6. Sei 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 231-16-2675 Usuel Residence of Decedent 18 M 2□ F 74 Yrs VIRGINIA Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yas 2□No Director MARYLAND ALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1012 USA. 14. Race - American Indian, Black, White, etc. OMBARD STREE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 X Yes 2 No If Yas, Give Year or Datea: 1 Never Married 2 Merried 1 Yes 2 No Specify Specify: BLACK 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mental Hygiens. 27 is marked other than "r r traumatic event, the Mag Elementary/Secondary (0-12) College (1-4or 5+) 6++GRADE FARBERS FRUIT ABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be TREGORV DELL (MN-UNKNOWN) 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 3805 DOLFIELD AVENUE, BALTIMORE, MD 21815 (FRIEND DOROTHY TOWLER 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of P Important: If its any injury or of once. 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete CROWNSVILLE CEMETERY 10-12-99 CROWNSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) of Funeral & 22. Name and Address of Facility 22. Name and Address of Facility JOSEPH IT. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE, MP. 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory not heart failure. List only one cause on each line. Physician /Medical Immediata Causa (Finel CANCER 18 month UN 9 disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due tu (or as a consequence of): Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown ρ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case refarred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Homa 5 Residence 6 Mother (Specify) 1 Yas 2 No Medical Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be detarmined Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed Division of Vital Records. or Attenda after death Director: A

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Pages 1 and 2 should

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Maryland

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To the Hospital o within 24 hours af To the Funeral D completely filled i State Registrar

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31. Date filed (Month, Day, Year) OCT 0 8 1999

29b. Signeture and title of certified

29a. Cartifier (Check only one)

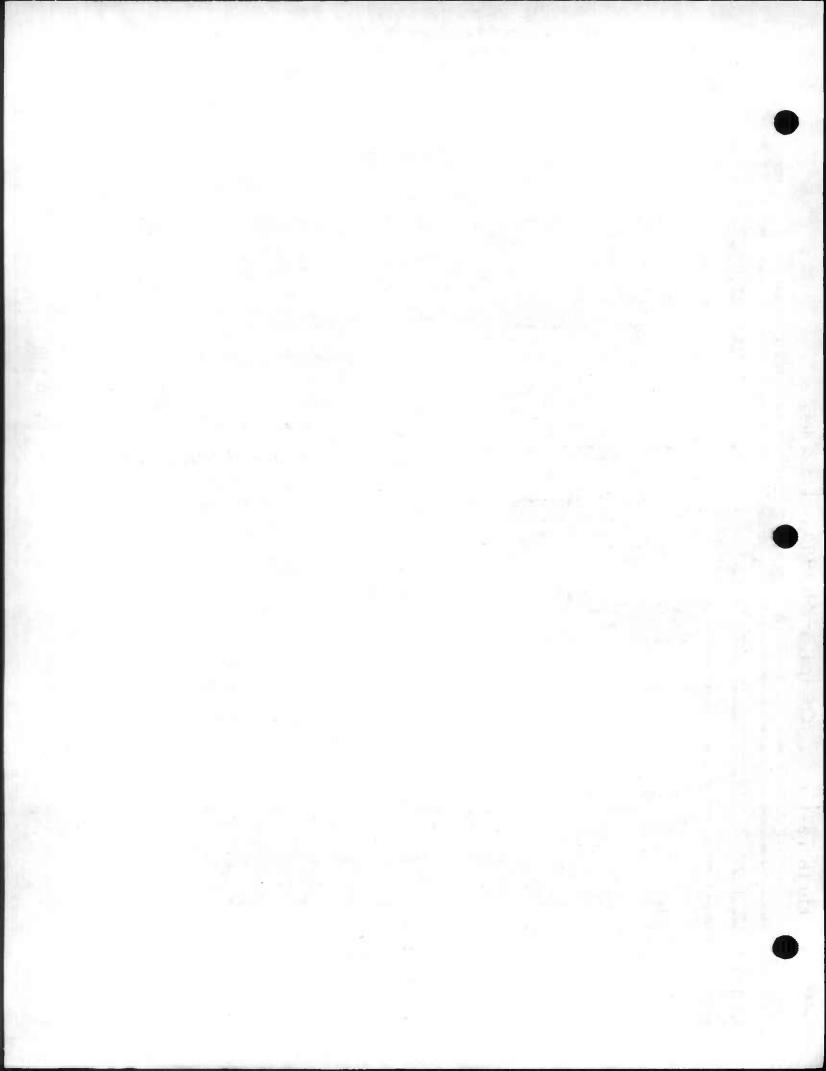
> 6701 6-Bm(32. Registrar's Signature

out oil person who completed cause of death (lloop 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

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Charles & Balto me



Completed page 2 Be Certification: To this unerai After death. 24 hours after deat Funeral Director: filled in by

25. Wes case referred to medical examiner?

1 Xes 2 □ No 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 0145AM 1 Yes 2 No 10-3-99 motor vehicle accident

6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State) 7-95 South at Volument Aug Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

We dicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier

5 Pending investigation

1 Yas 2 No

27. Manner of Death

1 Netural

21 Accident

3 ☐ Suicide

4 T Homicide

(Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

MYes 2□ No

October 5, 1999

Chuts 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute to 111. Pe

O.C.M.E. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

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31. Date filed (Month, Day, Year)

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32. Registrer's Signeture

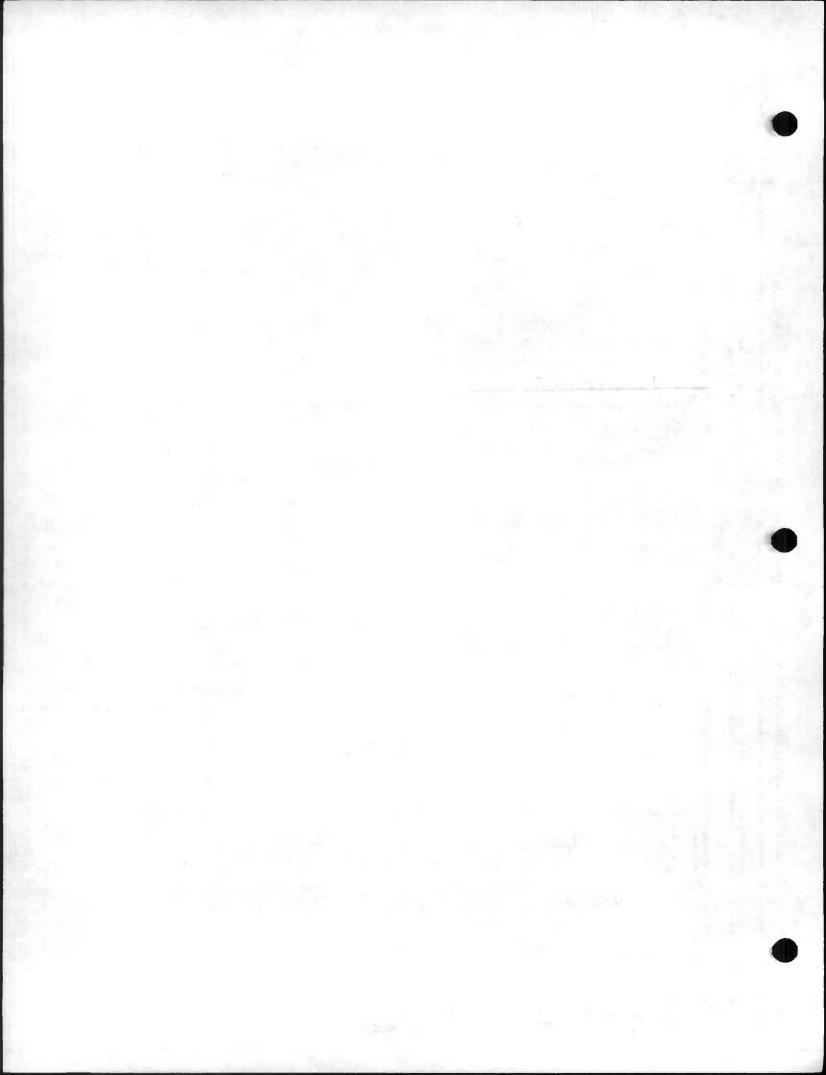
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Certificate of Death	Reg. No.	· ·			
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Physician /Medical Examiner

Funeral Director the Maryland

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 Is merked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, its Medical Examine I must be notified at any injury or other traumatic event, its Medical Examine I must be notified at 2 should be filed within 72 hours after c end Mental Hygiene. Is merked other than "natural", or Iten

Box 68760

P.O.

Division of Vital

3altimore, Maryland 21215-0020 1 D Buriel 2 □ Cremetion 3 □ Removal from State OAK LAWN CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility onkung Xemily 1100 521 **Physician** Immediate Ceuse (Finat diseese or condition resulting in deeth) /Medical Examiner Examine ettending physician and for use es the bunal-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury Physician/Medical thet initieted events resulting in death) Lest Pert II. Other eignificent conditione contributing to deeth but not resulting in the underlying ceuse given in Pert I. signed by Records, Š Completed DIABETER MELLITUR filled in by the funeral director, 25. Wes cese referred to medicat exeminer? Be 1 Yes 20 No Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA 2 After this 27, Menner of Deeth 28c. Injury et Work? Certification: Attending Maturel 5 Pending investigation al or Attendings efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours off To the Funeral Di 29a. Certifier Medical completely (Check only one) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (flem £3a) (Type, Print)

8 1999

OCT

1. Decedent's Neme (First, Middle, Last) SEPT. 28, 1999 11:18PM PATRICIA POPOVICH 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth CHURCH HOSPITAL BALTIMORE N/A 8. Dete of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 1□M 2XF Months Deys Hours 213-34-0128 Yrs 62 1937 MD. Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Instde City Limits MD. N/A BALTIMORE 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6211 BROWN AVE. 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10TH 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) WILLIAM KENNEY ELIZABETH CUMMINGS 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MICHAEL POPOVICH/HUSBAND 6211 BROWN AVE., BALTIMORE, MD. 21224 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 10/2/99 BALTIMORE, MD. CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE., BALTIMORE, MD. 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth MYO CAPPIAL (NFARCTION)
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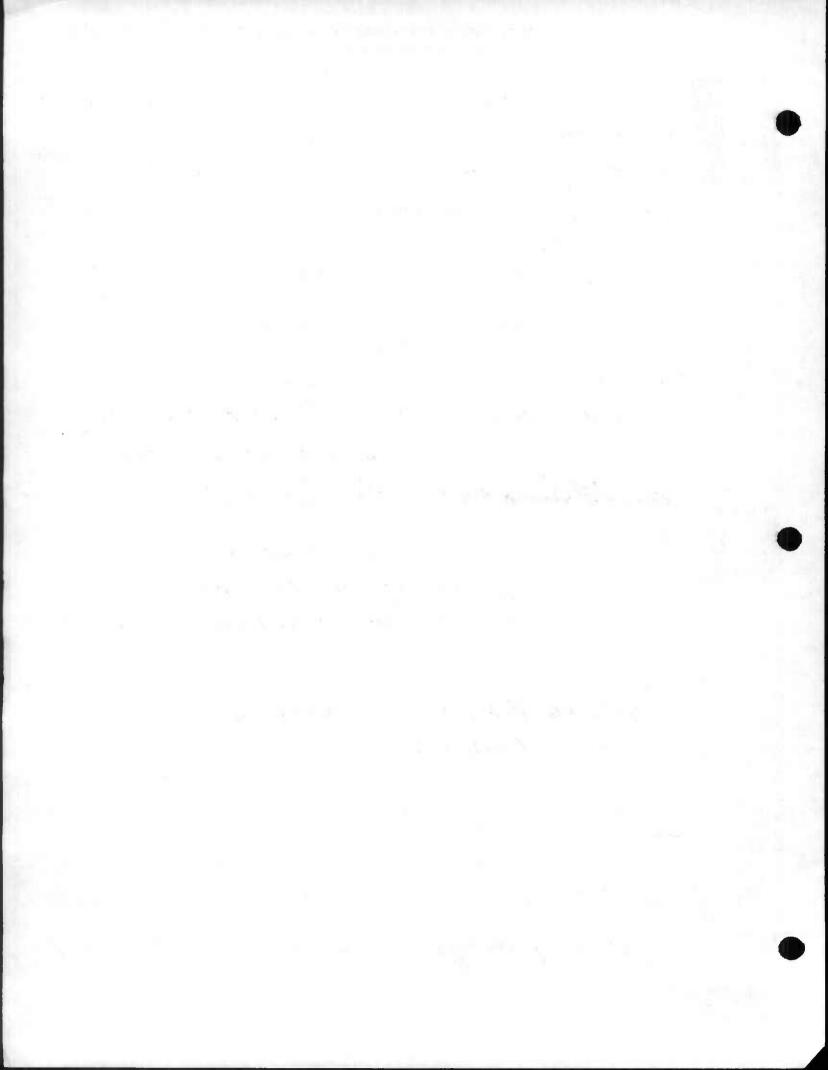
23b. Did tobecco use contribute to the cause of death? DIBABLING P. A.O.D. TO LOWER EXT. LEFT 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings aveileble prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

12 Sertifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Exeminer: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted. 29d. Dete stoned (Month, Dev. Year)

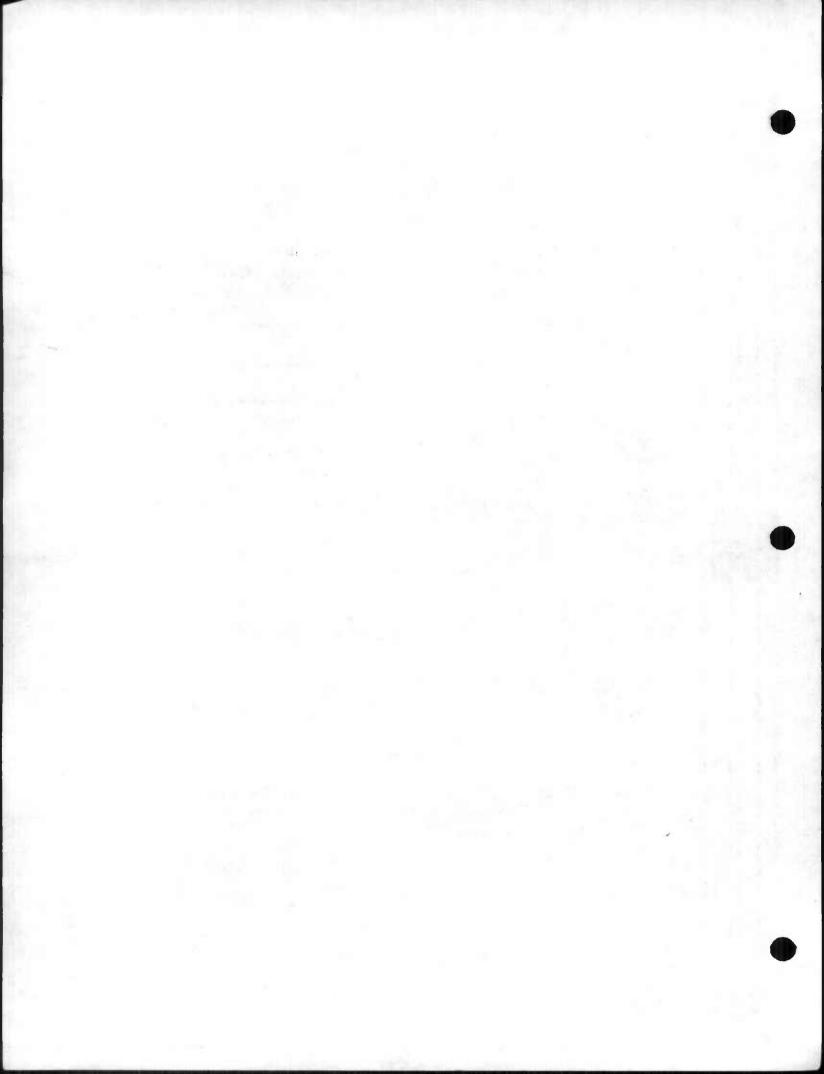
JOSE ORTIZ 100 N. BROADWAY BALTIMORE, MD. Υ. 32. Registrer's Signature 31. Dete filed (Month, Day, Year)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

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121	E E	ementery/Secondery (0-12)	College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired) CASHIER				FOOD		
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altimore mit. Pages 1. partment of He portant: If New y Injury or oth		1 Burial 2 Cremetion 4 Donetion 5 Other (S	Specify)		-	E CRI	EMATORY	10/8/9	9 BELTS	SVILLE,	MD.
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Physician	23a	Pert1. Enter the disease, o shock, o heart failure. Lis	complications that cause tonly one cause on each I	d the deeth. Do						Appro	oximeta al Between t and Death
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P.O. that the ded by the detached	Pert	Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contributs to the cause of death?			
	الم الم	Retroviral infection						1 Yes 2 No 3 Probably 4			4 Unknown
of Vital Records, P.O. Box Physician: The law requires that the death centric centrificate has been signed by the attending ral director, page 2 should be detached for use	Completed b							24a. Was perfo	en eutopsy omed?	24b. Were aut available completic of death?	prior to on of ceuse
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of Vita Physician: this certific and director,	0	examiner?	Hospitel: 1 Inpati	ent 2 ER/0	Outpatient 3	DOA	ther	Home 5□ Resi		er (Specify)	
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Division of To the Hospital or Attending Physiphic 24 hours after death. To the Funeral Director: After the completely filled in by the funeral process.		Certifier (Check only one) AS Certifying 2 Medical	ng Physician: To the best Examiner: On the basis of end menner st	of examinetion e	ge, deeth occu and/or invastig	urred et the tation, in my	tima, data and place opinion, death occ	s, end due to the urred at tha time,	causa(s) and me data end place,	enner es stated. and dua to the ca	ause(s)
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State of Maryland / Department of Health and Mental Hygiene

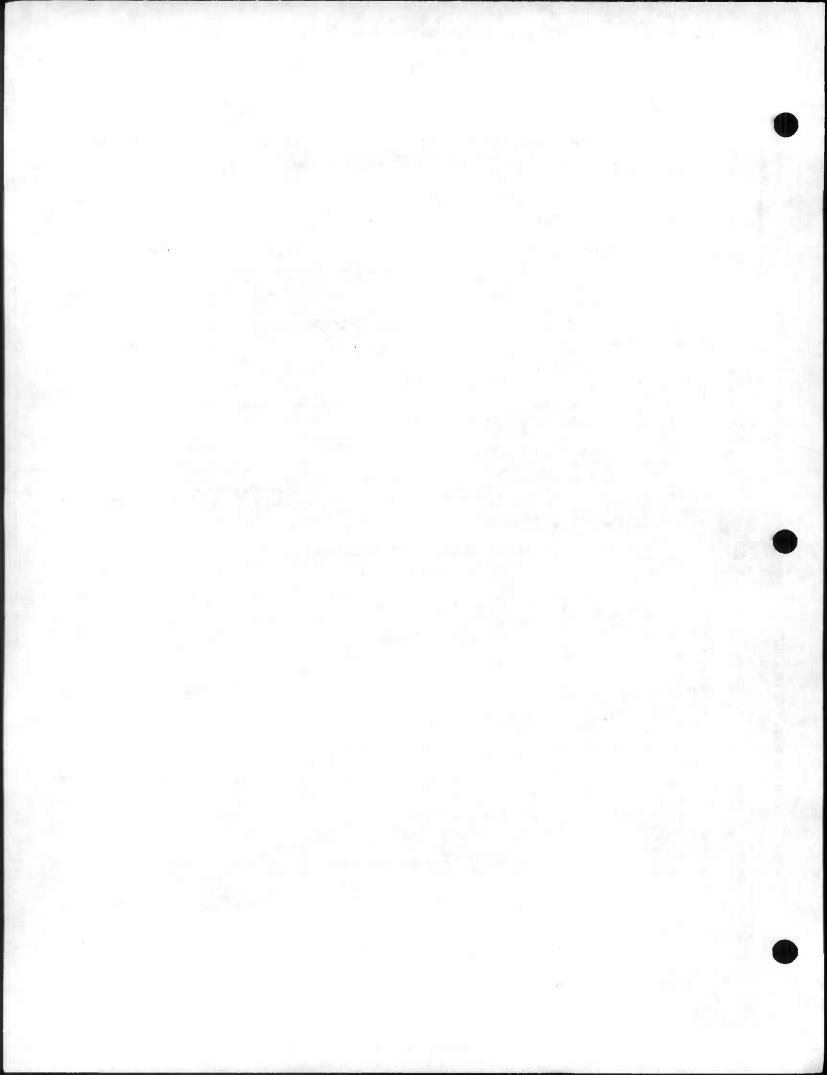
Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ANTTA RUDIN 5. 1999 4c. County of Deeth 1999 4:30 AM OCTOBER /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 8. Date of Birth (Month, Day, Year) NOV 24, 1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 20 F NEW YORK 354-14-2079 72 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 28a-f 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 1609 WOODLING WAY 21208 USA Funeral therms: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Raca - Amarican Indian, Bleck, White, etc. filed within 72 hours after 1 Yes 2/7 No 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify þ WHITE 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) TEACHER **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H ant; if them 27 is marked oth lury or other traumatic even Be **GOLDBERG ESKOLSKY** NATHAN GERTRUDE 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 LONG LAKE DR. MS. STACY RUDIN (DAUG.) OWINGS MILLS, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) BETH TFILOH 10/6/99 BALTIMORE, MD 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Linea 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final CEREBROVASCULAR ACCIDENT diseese or condition resulting in deeth) Examiner Due to (or as a consequence of) the burial-transit The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): pue Box 68760, Physician/Medical Due to (or es a consequence of): 88 188 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown MYOCARDIAL INFARCTION Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? DIABETES HYPERTENSION certificate 1 ☐ Yes 2 No 1 Yes 25 No or Attending Physicien: funeral director, 25. Wes case referred to medical examiner?
1 Yes 25 No. Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Naturel deeth. 1 Yes 2 No 2 Accident 24 hours after deet Funeral Director: 6 Could not be determined 3 Suicida 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) within 2 art. 29b. Signeture end title of certific 29c. License number 29d. Date signed (Month, Day, Year) (0-5-99 37254 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MD. 21204 31. Dete filed (Month, Day, Year) OCT 8 1999 82. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

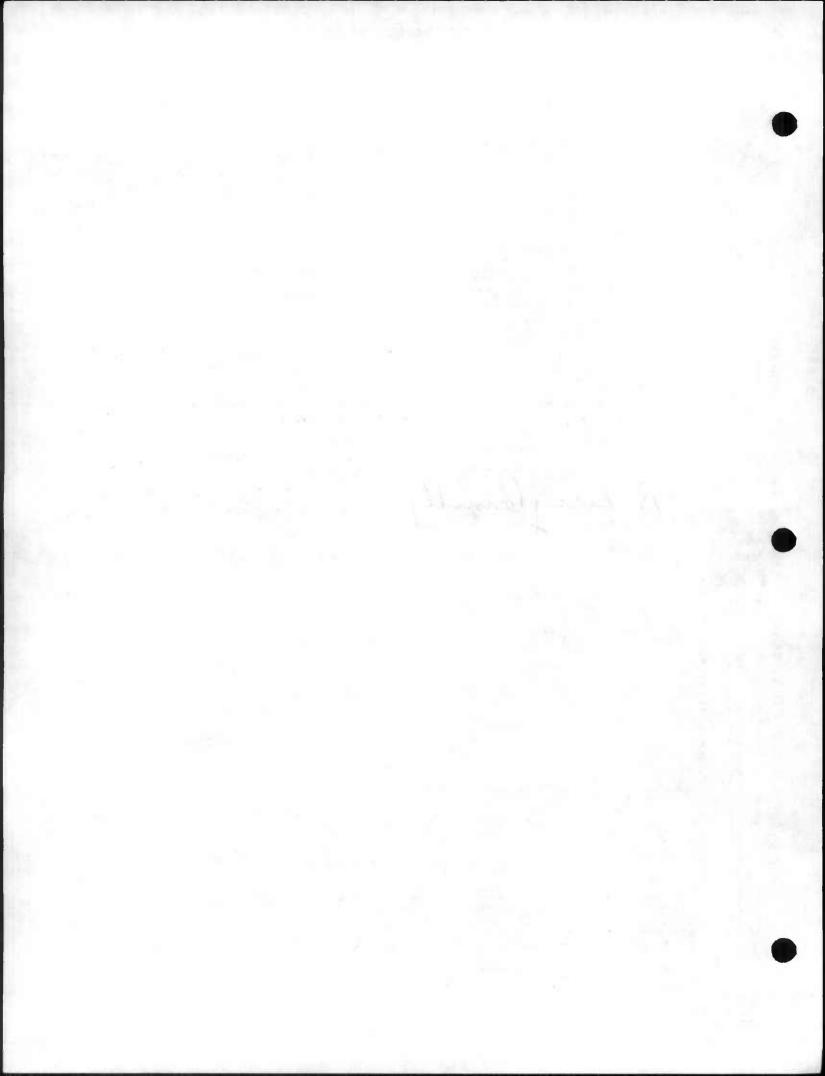
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State of Maryland / Department of Health and Mental Hygiene

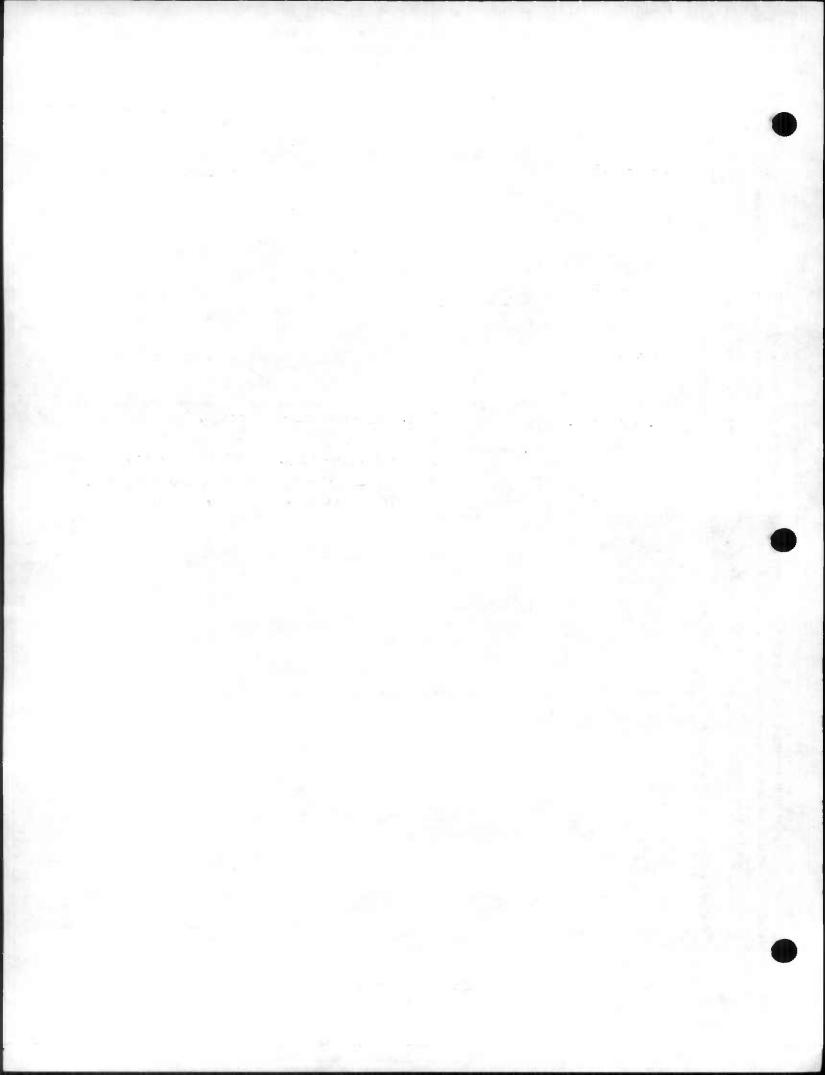
			Cer	tificate of	Death		Reg. No.	01000		
	1. Decedent's Neme (First, Middle, La	st)		2. Date of De Month		3. Time of Death				
Physician /Medical	LURA B SV			OCTOB						
Examiner	4a Facility Name (If not institution, give	a street end number)		4b. City, Tow	n, or Location of Deat	_				
	Eastpoint Nur	sing Home			Eas	stpoint Baltimore				
Funeral Director	5. Social Security Number 6. 5 234–10–5613	Sex 7. Age (In y/s	: last birthday) Yrs.	If Under 1 Year Months Days			th sy, Year) 1907	9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent									
Marylan a-f show thed at	Md. Baltime		ity, Town or Lo	Eastpo	oint			10d. Inside City Limits 1 ☐ Yes 2\(\overline{\chi} \overline		
office death with the Main the Main the Main the Main the Main the motified where all Director Funeral Director	10e. Street and Number 1046 Old North	Point Road		10f. Zip Code	21224		10g. Citizen of Wh US			
DV 1 by	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forcas? 1 Yes 2000 No If Yas, Giva Year or Dates:		Was Decedent of t Yas, specify Cut I ☐ Yas 2 2 No		in? (Specify Yes or No Puerto Rican, etc.)	ecify Yes or No- Rican, etc.) 14. Race - American Ind Black, Whita, etc. Specify: White			
5-0 72 ho	15. Decedent's E		16a. Deced	lent's Usuat Occu	pation	of working	16b. Kind of Busi	iness/Industry		
Maryiand 21215-0 d 2 should be filed within 72 hos th and Mental Hygiens. 7 is marked other than "natura traumatic event, the Middle. To Be Completed	Elementery/Secondery (0-12) 6th							Blackwell		
other of the C	17. Fathar's Neme (First, Middla, Last					lle, Maiden Sumame)				
aryiand 2 should be filed v and Mental Hygie a marked other t urmatic event, in	John Swiger				En	nily Lyons				
Maryica 2 should and Mer is marks is marks aumatic	19a. Intormant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Stree	t and Number	or Rural Route Numb	er, City or Town, S	tete, Zip Code)		
e, M 1 and 2 Health 9m 27 is ther tra	Linda Weaver / 1	Linda Weaver / niece				Baltimo	re Md. 21	222		
Baltimore, permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other once.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Plece of Dispo- cemetery, cren	sition (Name of netory or other ple	109)	Dete	20c. Location - C	ity or Town, State		
Baltimor permit. Pages Department of I Important: If its any injury or or once.	4 Donation 5 Other (Specif	y) I	ulaney	Valley (Cemeter	ry 10/8/99	Baltimo	ore Md.		
Physician /Medical Examiner	23a. Part1. Entar tha disaasa, or com shock, or heart teilure. List only Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate	a. Arferies. Dye 10:	clerote	yence of):	CE AVE.	Pral Home (Baltimore ardiac or respiretory a Weare	Md. 212	Approximate Interval Between Onset end Deeth 2 ym 2 ym		
- U 0 0	cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): d.									
Dry the detached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contributs to the cause of death			
The law requires the law requires the law seen signe, page 2 should be d							24a. Wes en autopsy performed? 24b. Were autopsy evailable prior completion of of death?			
T 2 - 6 5						10	Yes 2 No	1 Yas 2 No		
Partific sctor,	25. Was case reterred to medical examiner?				26. Place	of Deeth (Check only	one)			
Physician: T Physician: T this certificat ral director, pc	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA	her: 4 Nur	sing Home 5 ☐ Res	idence 6 Other	(Specify)		
VISION OF VITA Attending Physician: Ardeath. Sylvary the fundral director, by the fundral director, iffication: To Be (27. Manner of Death 1		28d. Describe	how injury occurre	d					
DIVISION C ball or Attending P rs after death. el Director: Attent led in by the funars Certification:	3 Suicide 6 Could not b	28f. Location City or To	(Street and Number wn, Stete)	r or Rural Route Number,						
DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29e. Certifier 11 Certifying Ph (Check only one) 2 Medicat Exam	yalclan: To the best of my kn niner: On the basis of examin and menner steted.	owledge, deeth ation end/or inv	occurred at the trestigation, in my	ime, date and opinion, death	place, and due to the cocurred at the time,	cause(s) and man date end plece, an	ner as stated. nd due to the cause(s)		
To th within To th comp	29b. Signature and fills of certifier	1. This		29c. Licen	se number	7	29d. Date signed 0 1	(Month, Day, Year)		
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, 1	Print) ELL WO	od Ab	E. BAC	TO, MD	21224		
State Registrar	31. Data filed (Magth Day, Year) 8 19	32. Registrer's Sign		Some	,			1		



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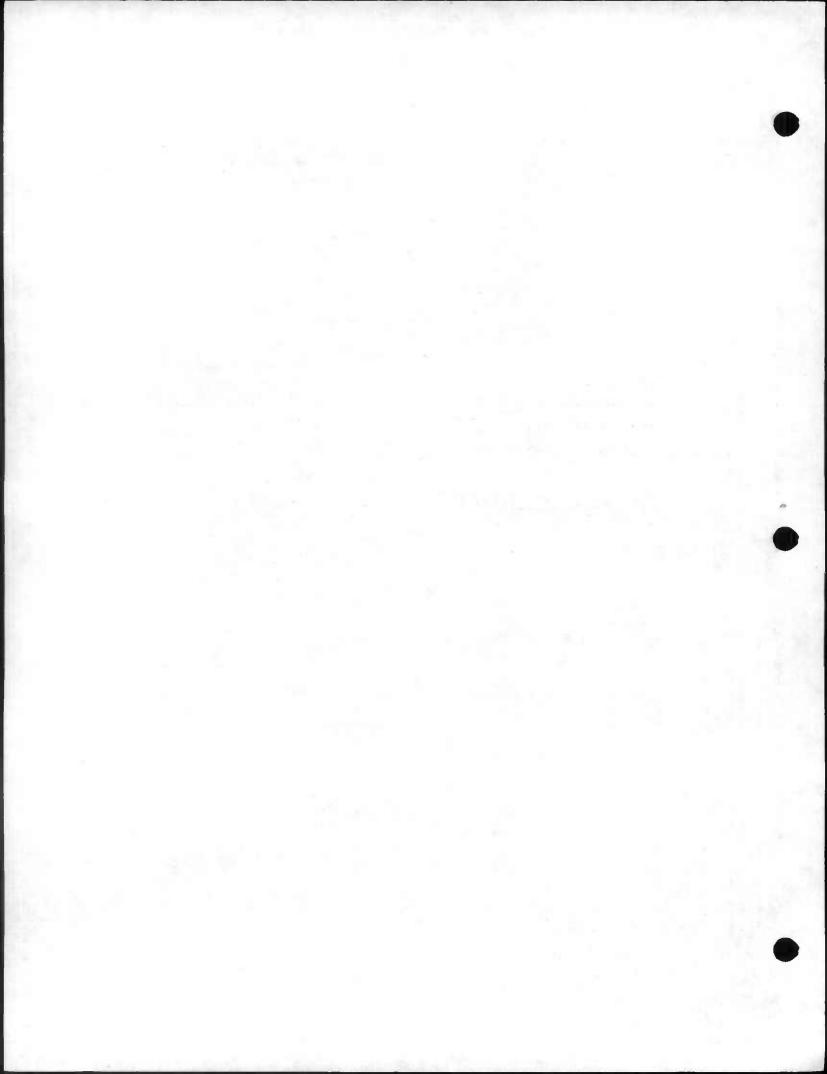
State of Maryland / Department of Health and Mental Hygiene

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		State of Maryle		rtificate of			ng. No.		1000		
Dhusisian	All the second and th	Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year 3. Time of I			
Physician /Medical	Florence Ann S	utton		October			5:30 am				
Examiner	4a Facility Name (If not institution, g	ive street end number)			4b. City, Town, or Lo	ocation of Death 4c. County of Death					
	Anne Arundel M	edical Center			Annapolis		Anne A	runde	1		
Funeral Director	199-10-5636	Sex 7. Age (In y	rs. last birthday, Yrs.	Months Days		8. Date of Birth (Month, Day, June 2,	Year) 1919	9. Birthplac Country Ohio	e (State or Foreign)		
the Maryland 25a-f show notified at ector	Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation			7,	10d.	. Inside City Limits		
o Ma	MD Anne A	rundel	Crownsv:	ille					1 ☐ Yes ACNO		
with the Ma a or 28a-f s the notified	10e. Street and Number			10f. Zip Code		10	og. Citizen of W	hat Country	?		
al late	941 Buttonwood	Trail		210	32		US	SA	A		
1020 Juns after death with the Maryla wit, or itsms 23a or 23a-f shor Examinat must be notified at by Funeral Director	11. Marital Status 1 Never Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ② No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - American k, White, etc Whi			
n 72 h n 72 h ''natur ledical	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of work d)	ing	ng 16b. Kind of Business/Industry				
Z1Z Z1 with diens. er than t than	12		Homer	maker			Own Ho	ome			
ind S tal Hygi d other event, I	17. Father's Neme (First, Middle, La.	e (First, Middle, A		Θ)							
Should be nd Mental marked o mentic eve	Paul Hofius				Rosina	Vaughan					
18 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	19a. Informant's Neme/Reletionship	(Type, Print)			t and Number or Run		-				
	Thomas E. Sutt				od Trail,						
Sallimore, Jemil. Pages 1 ar Department of Hea montant: if Item 2 my Injury or other 2008.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 0ur Lady of the Fields 10/09 Millersville, MD										
box 68 / 60, ant certificate be assected thending physician and for use as the burial-transit clan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Last	Due to	o (or as a conse		heck Track) o	rection	'n	1	day		
death death of for my f	Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.						23b. Did tobacco use contribute to the cause of death?				
that the death certified by the attending detached for use a Physician/M	Ochydration Hipertialena						1 Yes 2 No 3 Probably 4 Unknow				
The law requires that the death certificate has been signed by the attending page 2 should be detached for use a Completed by Physician/Me								availa	sutopsy findings able prior to eletion of cause ath?		
The law ata has page 2						1 □ Ye	s 2 DNo	1 D Y	/es 2□ No		
lician: The certificata rector, pag	25. Wes case referred to medical				26. Place of Deat	th (Check only on	e)				
hysici hysici his cer il direc	examiner?	Hospital:	□ ER/Outpatie	nt 3 DOA Ot	her: 4 Nursing Ho	ome 5 Reside	nce 6 Othe	er (Specify)			
UNISION OF VICE IN The Hospital of Attending Physician: The July & Hours affar death. The Tunneral Director: After this certificate he manely filled in by the funaral director, page ledical Certification: To Be Com	27. Menner of Death 1 Deatural 5 Pending 2 Accident investigati		28b. Time of Injury	Wo	ny at wk?] Yes 2 □ No	28d. Describe ho	w injury occurr	ed			
LIVISION C tal or Attending P rs after death. al Director: After ti led in by the funara Certification:	3 Suicide 4 Homicide Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, Stete)								Route Number,		
To the Hospital within 24 hours a Lo the Funeral Completely filled Medical Ce	29e. Certifier 1 Dertifying F (Check only one) 2 Medical Exp	hysician: To the best of my k miner: On the basis of exem end menner steted.	knowledge, deet ination end/or in	th occurred et the ti evestigation, in my	me, date and place, opinion, death occur	and due to the cared at the time, da	use(s) and me ate end piece, s	nner es state and due to th	ed. ne cause(s)		
TO WELL	29b. Signeture and title excertifier	1		29c. Licen	se number	25	9d. Date signed	(Month, Da	y, Year)		
11/2	Ma 1/1	inster 1	7030	123	8745		Oc1 (5,17	797		
W/1)	30. Name and address of person wh	completed cause of death (I	tem 23a) (Type)	Print) / /->	AVE	Anny	ouls	onD			
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature 9.	boards							



Box 68760. o مَ Records, Division of Vital

To the Hosp within 24 hor To the Fune completely fi Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

100

OCME

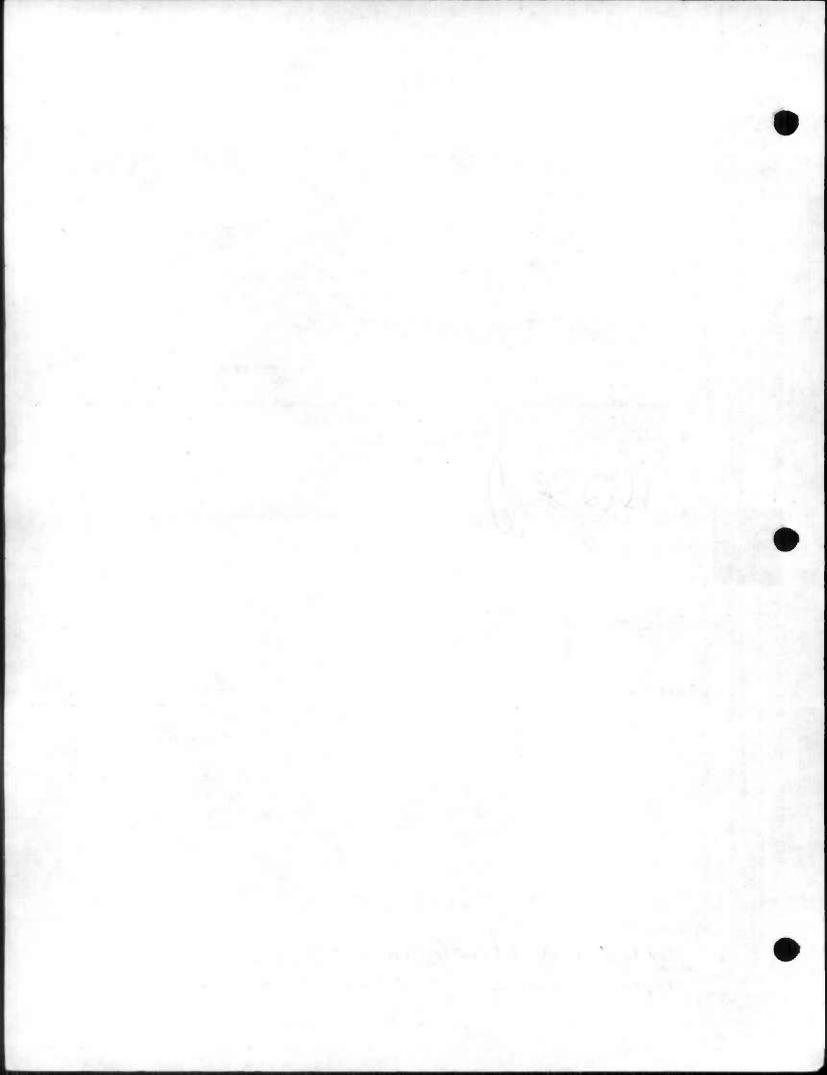
OCTOBER 6, 1999

Padentz 111 Penn Street, Baltimore, Maryland 21201

Stephen S. 12. State

29b. Signature and title of certified

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Vaai **Physician** DONNIE SHAULIS Oct. 1999 20:10 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical System Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours MM 2DF 167-40-9163 Director DEC 26, 1949 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A **Baltimore** 1 Yes 2 No Director than "natural", or items 23s or 28s-f the Medical Examiner must be notifie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1649 South Hanover Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Hygiene. Wher then "netural", or its 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: 3 White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Self-Employed parmit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Ison 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) 96 Francis Frank Shaulis Mary Ann Carter 19a. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Don P. Shaulis, Jr./son 4109 St. Thomas Ave. Baltimore, MD 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Metro Crematory, Inc. 10/07/99 4 Donetion Baltimore, MD 21. Signature Funeral Service Lice 22. Name and Address of Facility Cremation Society of Md., Inc. Gregorchik 299 Frederick Rd. Baltimore, MD A 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Finel Intracerebral Edema Herniation disease or condition resulting in death) Examiner Due to (or as a consequence of): Intracerebral Hemorrhage sician and burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es a consequence of): physician a Box 68760 Physician/Medical Dua to (or as a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed peen s certificate 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medicel examiner?
1 Yes No Be 26. Place of Deeth (Check only one) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Deeth Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1X Netural 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier

To the Hospital of within 24 hours at To the Funeral D edicai

DHMH 16 Rev 6/95

31. Date tiled (Month, Day, Year) State Registrar

(Check only one)

Thomas

29b. Signature and titla of certifier

K.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mattingly

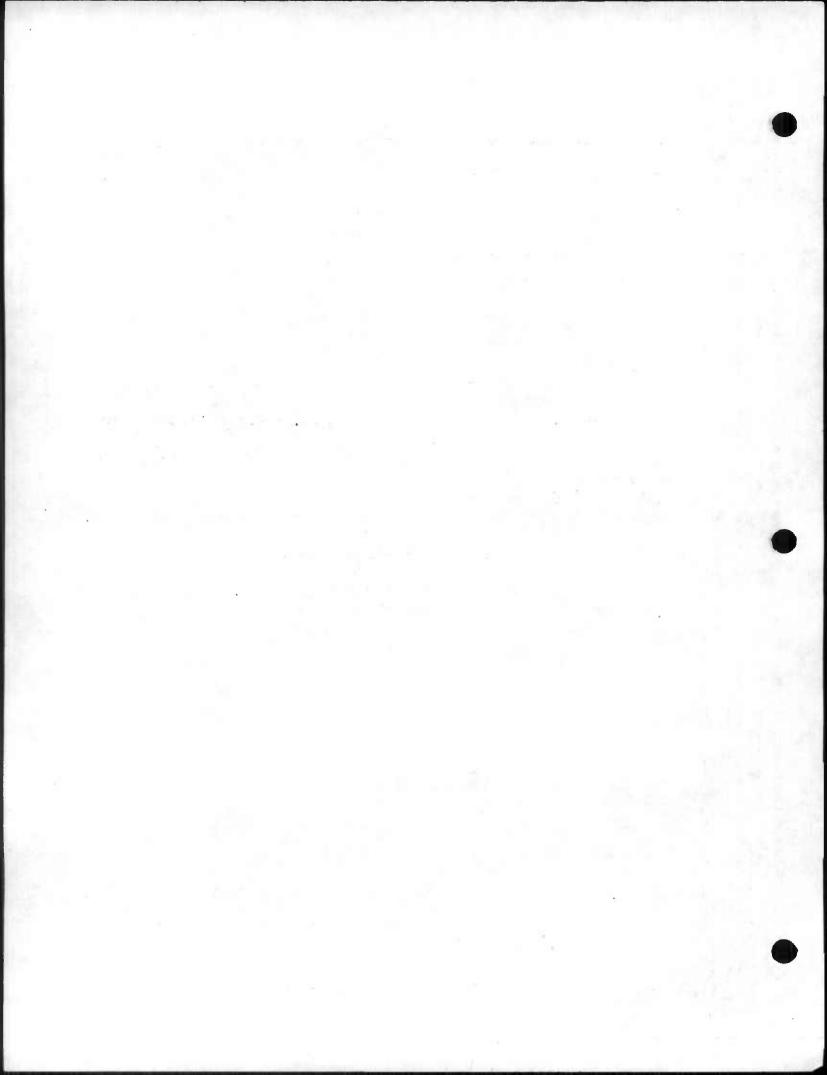
32. Registrar's Signeture

29c. License number

22 South Greene St. Baltimore, MD

29d. Dete signed (Month, Day, Year)

ORIGINAL

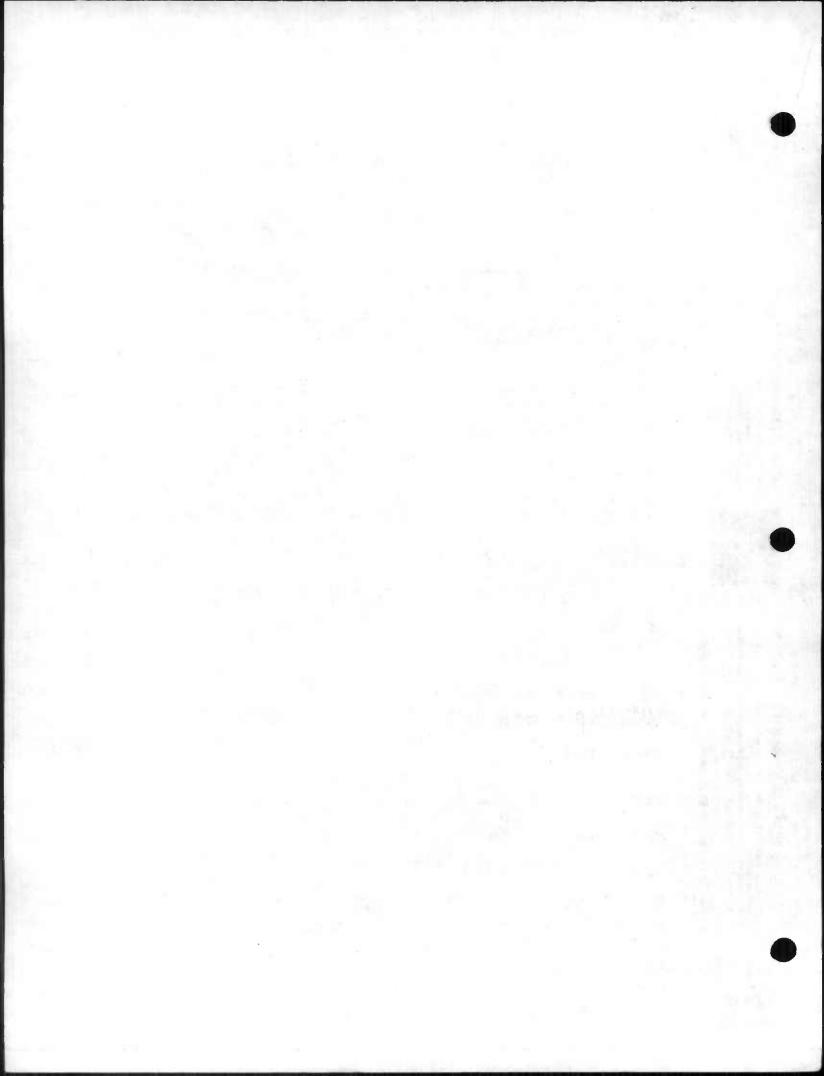


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month sullivan 36 ennis 10 05 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner Ba Himore Mary kind Hospita University dt If Under 24 Hrs. Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 2□ F 247-56-3843 Director 61 25, 1937 New Jersey Usuel Residence of Decedent death with the Maryland 10a State 10b Counts 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23a or 28a-f ahow the Madical Examinar must be notified at MD Howard 1 ☐ Yes 2 ☑ No Director Columbia 10a Street and Number 10f Zin Code 10g. Citizen of What Country? 6500 Belleview Drive U.S.A. Funeral 21046 12. Was Decedent Ever in U,S. Armed Forces?

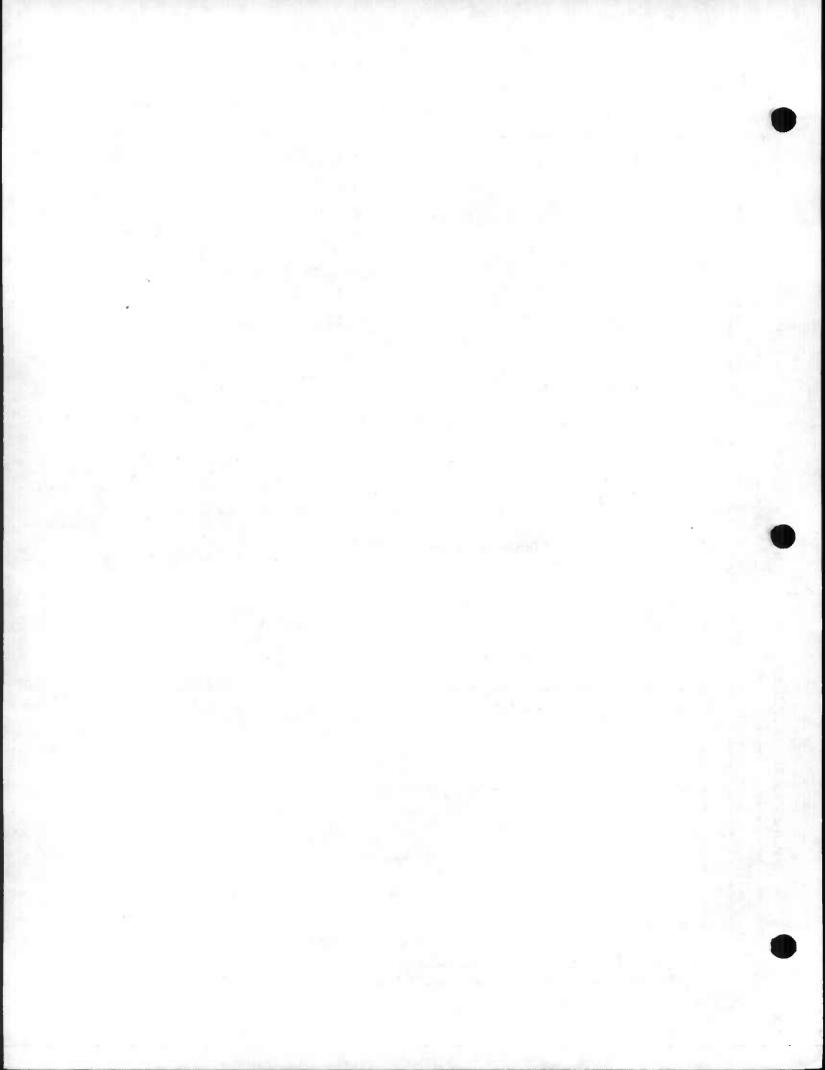
1 ☑ Yas 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck White etc. semit. Pages 1 and 2 should be filed within 72 hours after a Spannard of Health and Mental hygiene. Important if them 27 is marked other than "natural", or its my filery or other traumatic event, the Medical Exercise. 1 Never Married 2 XMarried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5+ Dental Field Dentist 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) B Dennis Martin Sullivan, Sr. Eileen Farrell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6500 Belleview Drive, Columbia, MD 21046 Rosemary Sullivan (Wife) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremetion 3 □ Removel from Stete 10/8/99 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 21. Signature of Fun 22. Name and Address of Facility Witzke Funeral Homes, Inc. Service Licenses 1630 Edmondson Avenue, Catonsville, MD 21228 e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, that only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Winutes Examiner Examiner oronary ears sician and burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a donsequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical Due to (or es e consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed to should be deta lemo Division of Vital Records. by The law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yas 200 No 2 No certificate Hospital or Attending Physician: funeral director. 25. Wes case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 W Neturel 28d Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier 5 29b. Signature end titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) 0 10/05/99 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Baltimore. Leeder Greene 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

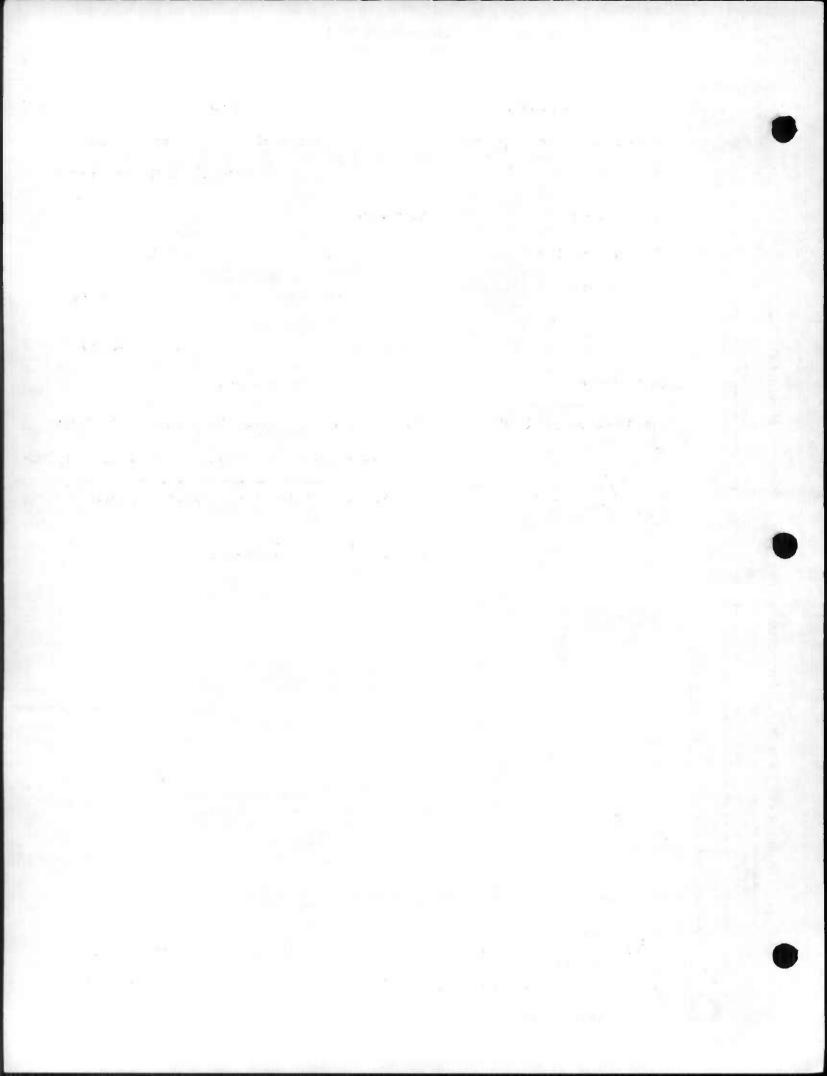
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	Saint Joseph	h Medical	Cent	er		Tows	on	Ba	altimore			
neral ector	5. Social Security Number 220–05–2375	6. Sex 1 → M 2 □ F	7. Age (In yrs. 78	last birthday) Yrs.	Months Days		in. (Month, Di	th ay, Year) 5, 1921	9. Birthplace (State or Foreig Country) Maryland			
	Usuel Residence of Decedent 10a. Stete 10b. Coun		10- 0	- Tour and an					104 1-14-05-11-5			
H 10		Baltimore		tonevil	le Mano	r			10d. Inside City Limit			
ect B	10e. Street and Number	Daitimore	Ca	CONSVII	10f. Zip Code			10g. Citizen of \				
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Completed by	3 Widowed 4 Divorce	1,04,01,0	ates:	I to Durd	-11-11-10-1	-1-41						
ete		ent's Education nest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of we life, DO NOT use retired)				16b. Kind of Business/Industry				
d m	Elementary/Secondary (0-12)) College (1-4or 5+)	Stock	Clerk	· · · · · · · · · · · · · · · · · · ·		Groce	ery Store			
Ö	17. Fether's Neme (First, Middle	e, Last)				18. Mother's N	Name (First, Middle	lame (First, Middle, Maiden Surname)				
To Be	Milton Slimme	r, Sr.				Madlin Jones						
-	19e. Informant's Name/Relation	nship (Type, Print)		19b. Mailing	Address (Stree	t and Number or	r Rural Route Number, City or Town, State, Zip Code)					
the burial-transit of the part of the traumatic event, the Months of the traumatic eve	Willa Slimmer	(Wife)		5930	Montgom	ery Stre	eet, Balt	imore, N	Maryland 21207			
	20a. Method of Disposition	• Fig		Place of Disposi	tion (Name of story or other pla	ice)	Date	20c. Location	City or Town, State			
	1 ☐ Burial 2 ☐ Cremetion 4 ☐ Don Glion 5 ☐ Other		State	-	Cemete		10/9/99	Sykesyi	lle, Maryland			
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility							neral Ho	omes. Inc.			
	1630 Edmondson Avenue, Catonsville, MD 21											
	Immrediate Cause (Final diseese or condition resulting in death)	a. b.		EPHALO								
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury C.											
Medical	that initiated events resulting in death) Last		W									
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by Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE							Yes 2 No	3 Probably 42 Unkno			
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Medical Certifical	29b. Signature and title of certif	ier		0	29c. Licen	se number			ed (Month, Day, Year)			
	nan	m	-0	thoo	D 3	0263		10-0	06-99			
	30. Name and eddress of perso	n who completed caus	e of death (Iter	n 23a) (Type, P	rint)				100			
\	30. Name and eddress of person FRANCIS KHOO				owson,	MARYL	AND 212	0 4				



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 31 610

					C	ertifica	te of	Death		R	eg. No.	0 0	101	U
		1. Decedent's Name (First, Mid					2. Date of Deat			Death				
ı	Physician	Martha River	s Sebera							October	5, 19	Year	11:4	5 AM
	/Medical Examiner	4a Facility Name (If not instituti	on, give street and nu	umber)				4b. City, Town	n, or Loc	ation of Death	4c. Count	y of Death		
		Corsica Hill	s Nursing	Home				Centre	vill	le	Quee	n Anne	es	
	Funeral	5. Social Security Number	6. Sax	7. Aga (In yrs.	last birthda	y) If Unde	or 1 Year Days		4 Hrs.	6. Date of Birth (Month, Day,	Year	9. Birthp	lace (Stata or	Foraign
	Director	154-24-5860	1 □ M 2 🔀 F	66	Yrs.	IAIOHERIS	Days	riouis	J	une 28,	1933	New	York	
П	۵ ,	Usual Residenca of Decedent 10a. State 10b. Count	he	10a Ci	ty, Town or	Location				T T T T			0d. Insida Cit	n. I imita
	aryle aho	MD Kent	•	100.01		ertow	'n						1 Tyes	
	Bert out				011000	-					0- 04	MD - 1 C - 1	53.74	
	Dir.	10e. Street and Number 7726 Country	Club Iona			101. 2	ip Code 2162	20			0g. Citizen of U.S.A.	What Coun	itry r	
	e 23			edent Ever in U	16 15	Was Door						14. Raca - Amarlcen Indian.		
Maryland 21215-0020	be filed within 72 hours efter deeth with the Maryland stell thygiene. Id other than "natural", or items 23a or 28a-f show avent, the Marical Examiner must be notified at swent, the Marical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Margin	Armed F arried 1 Tes If Yes, G	orces? 2 2 No live	,3.	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puarto Rican, atc.) □ Yes 2 □ No Specify:					Black, White, etc. Specify: White			
0-10	2 ho	15. Decede	ent's Education	n	16a. Dec	cedent's Us	ual Occur	pation	of modeln		16b. Kind of E	usiness/Inc	dustry	
215	ed within 72 ho ygiene. nor than "natura it, the Westerl Completed	Elamantary/Secondary (0-12)	est grade complated, College	(1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)				or working	9	T A			
21	d withir or than the W	, (5.1.7,	Exec	cutive	3				Law As	SSOCIA	ation			
pu	tel Hygin d other avent, II	17. Father's Name (First, Middle	a, Last)							(First, Middle, I	Vaiden Suma	me)		
yla	and Mentel and Mentel or marked or umatic ave	Samuel Rivers						Berth	а ко	CKS				
lar		19a. Informant's Name/Relation			19b. Ma	Mailing Addrass (Street and Number or Rural Route Number, City or Town								
		Donald Sebera	(Husband)					Club :	Lane	, Chest			21620)
ore	of H of H or off	20a. Method of Disposition 1 ☑ Burial , 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nama of cemetery, crematory or other place)									20c. Location			
E	Peg ment ant: l	4 Donation 5 Other		St	. Lou:			-	()/9/99	Clarks	ville	, Mary	land
Baltimore,	permit. Depart Import any in	21. Signature of Junetai Service	e Licensee					ss of Facility Knolls	WILZ	ke Fundad, Col	eral Ho	omes, Marv	Inc.	1045
		23a. Part1. Enter the disease, of shock, or heart failure. List	or complications that	caused the deal	1								Approximata Interval Bety	3
4	Physician	Sipon Maail landie. Ci.	of Orly Orla Causa Off	agon ma.								1	Onset and D	
d	/Medical	Immediate Cause (Final disease or condition resulting in death) a. Amy ohophic Lateral Sclerosis /yr												
	Examiner .	Due to (or as a consequence ot):								1	17.			
	ie d		6									i		
1	rificate be executed against the buriel-transit es the buriel-transit Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury c.												
68760,≏	ouriel ouriel													
87	physicians the burner of the b	that initiated avents rasulting in death) Last	equence of):										
	certifi nding use es		d											
Вох	ath for a													
P.0.	the de	Part II. Other significant condit	tions contributing to d	death but not res	sulting in the	undarlying	ceusa gi	van in Part I.			lid tobacco use contributs to the cause of death? ☐ Yes 2☐ No 3☐ Probably 4∰Wnknown			
	ed by detail									1 Y	es 2 No	3 Pro	bably 4 194	⊌nknown
Records,	The law requires that the de sale has been signed by the c page 2 should be detached Completed by Physic									24a. Was a perform		av	ere autopsy ti allabte prior to impletion of ca death?	0
	The law ste hes page 2:									1 □ Y	es 2 No	1[☐Yes 2☐	No
Vital	entifice ector, p	25. Was cese referred to medic	el					26. Place o	of Death	(Check only or				
>	Physician: this certific ral director. TO Be (exa <i>m</i> iner? 1 ☐ Yes 2 █ No	Hospital:	Inpatient 2	ER/Outpat	ient 3 🗆 🖸	ON ON			e 5 Reside		ther (Specif	fv)	
o	Physeral eral	27. Manner of Daath	28a. Date	of Injury nth, Day Year)	28b. Time	of	28c. Inju Wo			8d. Describe h			,,	
0	Attending or death. ector: After by the fune iffication	1 Pend 2 Accident inves	tigation (Moi	iniii, Day 19ai)	Injun	М		Yes 2 N	0					
Division	tal or Attending P rs efter death. al Director: After t led in by the funera Certification:	3 Suicide 6 Could 4 Homicide deter	mined 286. Plac	e of Injury - At h	ome, farm,	street, facto	ry, office		2	Bf. Location (S City or Town		ber or Run	al Routa Numi	ber,
Ö	s efte	TOMOGO	Dulid	ing, atc. (Speci	· <i>y</i>)					ony or row	r, orato,			
	To the Hospital or Attending Physician: The lawithin 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Cartifiar (Check only one) 2 Madica	ing Physician: To the i Examiner: On the b and man	e best of my kno basis of examina nnar statad.	owledga, de ation and/or	ath occurre investigatio	d at the ti	ma, date and opinion, death	place, ar occurre	nd due to the c d at tha tima, d	ause(s) and n ata and place	nanner as s , and dua t	itatad. o tha cause(s)
	To the Young	29b. Signature and title of the	iar					se nu <i>m</i> ber			9d. Date sign			
	/	> 4 (1)X	1				1	2203	25		101	11/5	9	
	5	30. Name and addrass of perso	who complated cau	isa of death (Ite	m 23a) (Typ	e, Print)	0,	, , ,	- 0		/-	- / -		
		Gan I:	Saras	re à	2102	12, 0	onal	Driv.	4	Clurk	- M	13 2,	1619	
	State	31. Date filed (Month, Day, Yea	7) 32.1	Ragistrar's Sign	atura	1.	1	-						
	Registrar	DCT	X 1000	2444	M	19	100	21/2/						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SPRUCE BANK Dey OCTOBER 6,1995 CLARA

10f. Zip Code

21133

1 ☐ Yes 2 ☑ No Specify:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1420 HV

BALTIMORE

Maryland

10a, Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specity: White

U.S.A.

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 K No

21228

Approximete Intervel Between Onset end Death

24b. Were autopsy findings eveilable prior to

completion of cause of death? 1 Yes 25 No

4b. City, Town, or Location of Death 4c. County of Death

RANDALLSTOWN | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 14, 1908

Physician /Medical Examiner

4s Facility Neme (If not institution, give street and number)

10h County

5415 Old Court Road

1 Never Merried 2 Merried

3 Widowed 4 □ Divorced

Baltimore

6. Sex

1□M 2□F

GUSPITAL

12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:

7. Age (In yrs. last birthday)

10c. City, Town or Location

Randallstown

NORTHWEST

5. Sociel Security Number

216-07-2207

10e Stete

Director

Funeral

MD

11 Marital Status

10e Street and Number

Usuel Residence of Decedent

Funeral Director

the Meryland r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after deeth with 1 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", or flems 23e or 2 ents injury or other traumatic event, the Maries is a constant. Maryland 21215-0020 Saltimore,

Physician

/Medical

Examiner

Division of Vital Records, P.O. or Attending Physician:

24 hours after death. Hospital completely within 2 the th

filled in by

31. Dete filed (Month, Day, Year)

Be

Certification: To

Be Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unk unk unk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t 9e. informent's Neme/Reletionship (Type, Print) Arthur Drager (Attorney) 5 Light Street #510, Baltimore, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 10/11/99Pikesville, Maryland Druid Ridge Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fundal Service Licensee 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 23a (Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, such as cardiac or respiratory errest, or heart feilure. List only one cause on each tine. RESPIRATORY FAILURE

Due to (or as a consequence of):

PNEUMONIA

Due to (or es a consequence of): tmmediete Cause (Finel disease or condition resulting in deeth) Examine Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest PSEUDOMONAS Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 I Inknown þ Completed 24a. Wes an eutopsy performed? 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 200No 1 Dhpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending 1 Aaturel 1 Yes 2 No investigation 2 Accident 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. Medical 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number D37333 OCTOBERG 1998

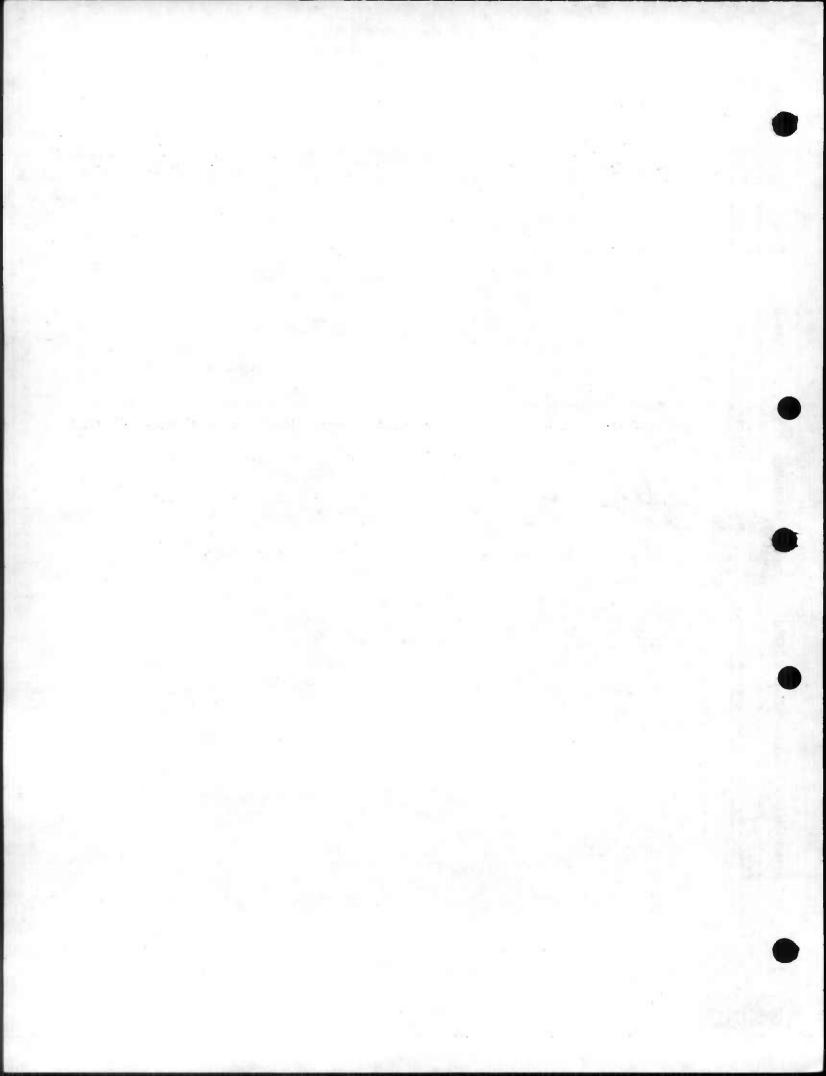
Registrar **DHMH 16 Rev 6/95**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVIMA, NHC, BALTO. MOZ1133

RAVIMA, NHC,

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #9,11,12,15,16a-b,17,18,19a-b perABG792 2/9/2001 EWCertificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month 35 **Physician** 1058 TALLON 99 09 /Medical 4a Facility Nema (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis ElderCare Cromwell Center Baltimore Baltimore H Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sax If Under 1 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 15M 20 F Months Days Director 78 April 23,1921 unknown 215-16-9012 Usual Rasidance of Deceda 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits show. 1 ☐ Yas 2 ☑ No Director 288-1 Baltimore Baltimore 200 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 8710 Emge Road Berns 23s 21234 unknown Funeral 12. Was Decedant Evar In U.S. Armed Forces2 un known. 1 ☑ Yas. 2 ☐ No If Yas, Giva Yeer or Detes: 11. Maritel Status unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc 72 hours after 1 Nevar Married 2 Merried altimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced unknown Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Hygiene. Hygiene. Other then "n Collega (1-4or 5+) unknown Elementery/Secondery (0-12) 12 Aircraft unknown Engineer unknown unknown permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be unknown Edith Mabel Price unknown Perfecto Tallon 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) unknown Louis Tallon/Brother unknown 5860 W. 9th Lane, Hialeah, FL 33012 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Nother (Specify) in state 21. Signature of Full Paral Sarvice Licensee 22. Name and Addrass of Facility Wade Director State Anatomy Board, 655 W. Baltimore St., Ronald S. rom/1.W Baltimore, MD 21201 Part1. Enter the diseasa, or complications that caused tha deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one ceuse on aech lina. Approximate Interval Batween Onset and Death **Physician** /Medical Immediete Causa (Final URINARY OF disaasa or condition rasulting In daath) Examine Dua to (or as a consequence of) Examiner CM CHTI physicien and the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of) VASCULAR DISEACE PERIPHERAL Box 68760 Physician/Medical Dua to (or as a consequance of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert t. 23b. Did tobacco usa contributa to the causa of death? 3 Probably 4 Onknown 1 Yes 2 No been signed I should be det Division of Vital Records. by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yas 2 No 1 Yas 20 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was casa raferred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 20 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homlcide 24 hours edical within 24 hou To the Funer completely fil 1 Cortifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 29a. Cartifier (Check only one) 2 Madical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, death occurred at the tima, date and placa, end due to the cause(s) and manner stated. the th 29b. Signature and title of earlifier 29c. License number 29d. Data signed (Month, Day, Year) 10/01 D52228 99

Registrar

State

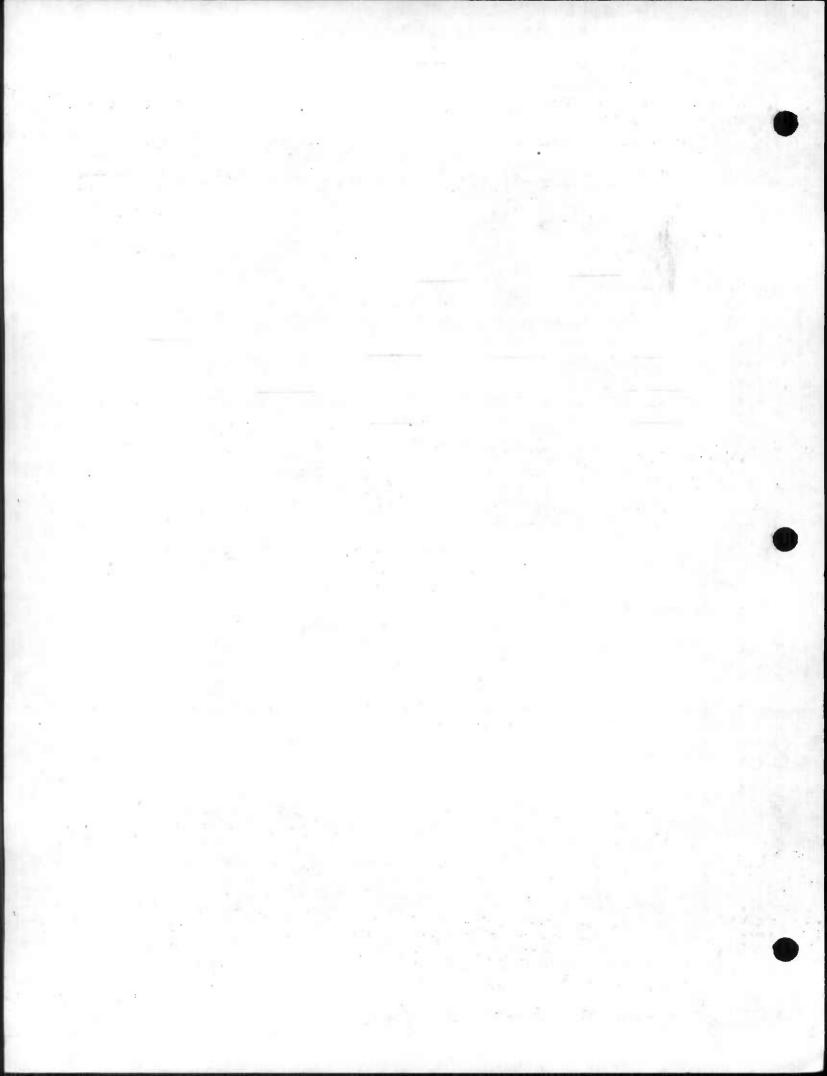
MIDULKUMAR 31. Date filed (Month, Day, Year)

0 8 1999

3007 E.NORTHERN PKWY BALTIMORE MD 21214

30. Name and address of person who complated cause of death (Item 23a) (Type, Print) BHALDDIYA, MID

32. Registrer's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Death 3. Tima of Death Month October MARY ANN WILLIS 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Dea Salvare enter dale If Undar 1 Yaar 8. Dete of Birth (Month, Day, July 21 7. Age (Inlyrs. last birthday) Birthplaca (Steta or Foreign Country) 5. Social Security Number 219–38–8416 Months Deys 1□ M 25 F 58 1941 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore Middle River 1 ☐ Yes 💥 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Fuselage Ave. 21220 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armad Forces? 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2X No If Yes, Give 1 Yes 2X No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 2yr Homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) James Edward Yeager Ettie Walker 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Sharon Riley / daughter 1201 Fuselage Ave. Baltimore Md. 21220 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 XBurlel 2 Cremetion 3 Removel from State Parkwood Cemetery 10/8/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Connelly Funeral Home of Essex Onne 300 Mace AVe. Baltimore Md. 21221 Approximete Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? 2X No 1 Yes 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 27. Menner of Death 28a. Data of fnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be datarmined 3 Suicida 281. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, fectory, office building, atc. (Specify) 4 | Homicida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and plece, end due to the cause(s) and mennar as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) end mannar stated. 29e. Certifier (Check only one)

The law requires that the death certificate be execu Box 68760. P.0. Records, certificate Division of Vital or Attending Physician: this After

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

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238

Pages 1 and 2 should be nent of Health and Mental

altimore,

If Norm 27

Physician /Medical

Examiner

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

USB signed by the atte page 2 funeral director. after death. filled in by To the Hospital c within 24 hours al To the Funeral D completely

> State Registrar

DHMH 16 Rev 6/95

31. Date filad (Month, Dey, Year 8 1999

29b. Signeture and title of cartifier

Dr Khin W Myint

Khin Win Mymit

9000 Franklin 32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

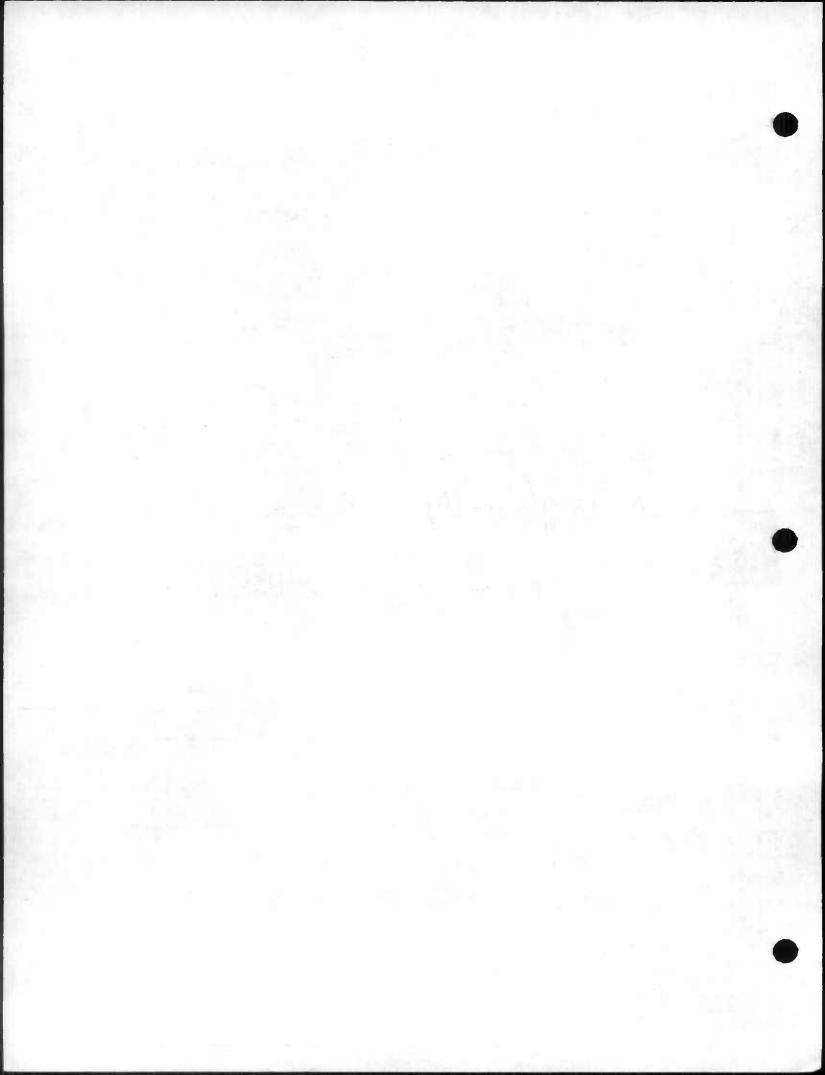
29c. License number

Drive

ORIGINAL

29d. Data signed (Month, Day, Year)

Baltimore, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician	1. Do	cedent's Neme (First, Middle, Las	ot)	Ochin	ioate or	Death	2. Dete of De	Reg. No.	3. Time f = th
10.0 . 11 . 1			ly Weaver				Month 1 0	Day	Year 1999 B:05 PN
/Medicai Examiner	4e. F	ecility Neme (If not institution, give	street end number)			4b. City, Town, or I	ocation of Deet		
		Mennonite F	'ellowshi Ho	me, Ind	o.	Hagers		Wa	shington
Funeral Director	2	, , , , ,	9x 7. Age (In yrs. 85		Under 1 Year lonths Deys		8. Dete of Bir (Month, Da 12-1	th ry, <i>Year)</i> 8–1913	9. Birthplece (State or Foreign Country) U.S.A.
Hygiene. Hygien	_	i Rasidanca of Decadent Stete 10b. County	10c. Cit	y, Town or Locati	on				10d. Inside City Limits
to to	m	D WASHING	TON HA	GERSTOW	N				1 ☐ Yes 2 No
be notted Director	10e.	Street end Number			10f. Zip Code			10g. Citizen of V	Whet Country?
23a c	1.	2349 HUYETT	LANE		2174	10		USA	
Examiner must be notified at Examiner must be notified at by Funeral Director	3	leritel Stetus Never Merried 2 Married Widowed 4 Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		Decedent of es, specify Cul Yes 2 No	Hispanic Origin? (Spen, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify	ea - American Indien, ck, White, atc.
t, tra Medical Exe Completed by		15. Decedent's Ed (Specify only highest gra-	ucation	16a. Deceden	's Usuei Occu	pation	kina	16b. Kind of Bu	usinass/Industry
ont, tra Med	Eli	mentery/Secondary (0-12)	College (1-4or 5+)	lifa. DO	NOT use retin	during most of worded) IER'S NATURI	A) Emac	NUTRITI	MAL FOODS
		ether's Neme (First, Middle, Last)		CO OMO	ER WEH	18. Mother's Nen			
D 9 III		JACOB G.	BRUCKHART			MINN		HELLEY	
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Please Type or Print in Biack Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** 7:06Ar OCTOBEL 1999 06 /Medical 4a Facility Name (If not institution, give street and number) 4b. Cltv. et, or Location of Death 4c. County of Deeth Examiner OMNS IMORE If Und 7. Age (In yrs. last birthday) 5. Sociel Security Number 8. Data of Birth (Month, Dey, Year) Birthplace (Steta or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 🛛 F Director 213-07-5104 March 29,1912 Maryland Usual Residance of Decedent the Merylend 10e Stete 10b Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Baltimore Dundalk 1 ☐ Yas 2 HNo MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 United States of America 21222 items 23s 7900 Charlesmont Road 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - Amarican Indian 11. Maritel Stetus permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mentel thygiene. Important: If Itam 27 is marked other than "natural", or itan eny injury or other traumatic avent, the Medical Espera Bleck, White, etc. 1 Never Merried 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: p 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 9 yrs 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unknown Frank Yeager 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 7900 Charlesmont Road Balto., MD 21222 Carlton B. Willey, Jr./Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel Irom State Hilltop Service Corp. 10/7/99 Towson, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Fecility The Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, MD 21222 Dundalk, Inc. 23e. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart lailure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner the death certificate be executed physician and the burial-tren Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Box 68760. MRONIEC ISCHEMIC Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No Probably 4 Unknown Records. by. 24b. Were eutopsy lindings evailable prior to Completed 24a. Wes en eutopsy completion of cause of death? page 2 : 2 No 1 Yes 1 Yes 20 No. certificate Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Mopatient Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After Neturel 5 Pending Invastigetion n 24 hours after death.

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pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signetura end title of certilier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Dete liled (Month, Dey, Year)

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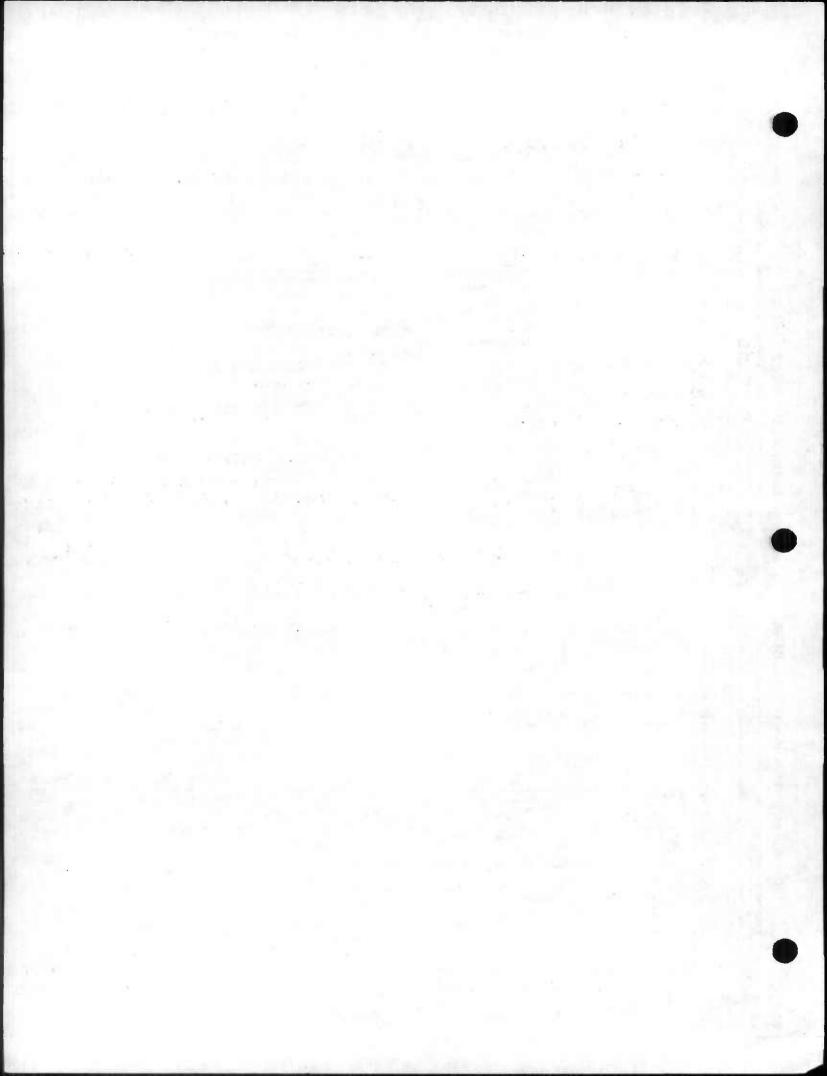
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30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #5 PER FH G776 10/08/99 AH 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death **Physician** WILLIAM WATSON OCTOBER 01, 1999 2:15 /Medical 4e. Facility Nama (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner ESSEX if Under 24 Hrs. RIVERVIEW CARE CENTER BALTIMORE 5 Social Security Number 5/8-52-6125 if Undar 1 Year 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpleca (Stata or Foraign Country) **Funeral** Days Hours 1√2 M 2□ F 76 Yrs Director Scotland MARCH 09,1923 Usuel Rasidanca of Dacedant the Marylend 10a, Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic svent, the Medical Examiner must be notified at Director 1 Yas 2K No Dundalk Maryland Baltimore 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 6 United States 21222 238 8217 Cornwall Road Herms 12. Was Dacedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Raca - American Indien, Biack, White, etc. filed within 72 hours efter t ☐ Yes 2 ☐ KNo If Yas, Giva Year or Detas: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yas 2 ☐No Specify: Specify: by 3 StWidowad 4 ☐ Divorced White Completed 15. Dacedant's Education (Spacify only highast grada complated) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Etementary/Secondery (0-12) Cotlege (1-4or 5+) Bricklayer / Mason Masonry Not Known 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meldan Surnama) Peges 1 end 2 should be finent of Heelth and Mentel Hint: If Item 27 is marked of Watson Not Known Not Known 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Heelth ar Important: If item 27 is any injury or other trau Arthur Drager 5 Light Street Suite 510 Baltimore, MD 21202 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crametory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Moreland Memorial Park 10/8/99 Parkville, Maryland 21. Signature of Furieral Sarvice Licensea 22. Nama end Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximata Intarval Between Onset and Deeth on or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiretory errast, **Physician** /Medical Immediata Causa (Finel disaasa or condition resulting in death) Examiner that the death certificate be executed Sequantially list conditions, if eny, laading to Immadiata cousa. Entar Underlying Causa (Disaasa or tnjury thet Initiated avants resulting In daath) Last Dua to (or as a consequence of): Physician/Medical the Dua to (or es a consequance of): signed by the el Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings avaitable prior to completion of causa of daath? Completed 24a. Was an eutopsy performed? page 2 certificate 2000 1 ☐ Yas 2000No 1 Yas Division of Vital ai or Attending Physicien: To s after deeth. ii Director: After this certificat 25. Was case refarred to medical exeminer? Be 26. Place of Deeth (Check only ona) Hospital: Other: 42 yursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 28e. Deta of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident in by the 3 Sulcida 6 Could not be detarmined 28e. Plece of Injury - At homa, farm, straat, fectory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 D Homicide Hospitai within 24 hours a To the Funersi edicai 29a. Cartifiar ticontribing Physician: To tha bast of my knowladga, daath occurred at tha time, data and placa, and dua to tha causa(s) end menner es steted. 2 Medicel Examinar: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. ŝ 29d. Date signed (Month, Pay, Year)
0 clober 6 19 29b. Signature and titla of certiflat 29c. Licensa numbar, D 30661 of death (ttam 23a) (Type, Print) SIREESH TRIPURANENT

State Registrar **DHMH 16 Rev 6/95**

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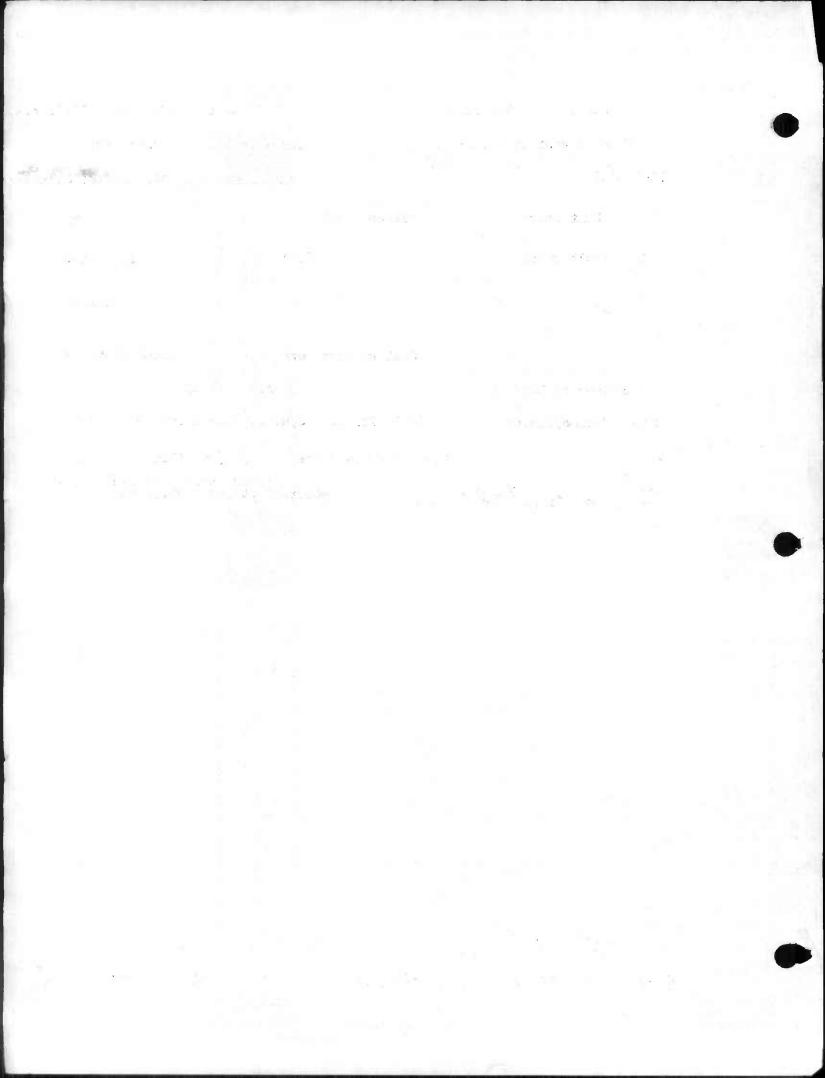
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To the Hospital or Attending Physician: The law requires that the death certificate be exacuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic	edicai C	29a. Certifier (Check only one)	1 Cartifying Phy	Insr: On the basis	s of exemine								
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Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Welkie 4, 1999 Oct. 11:18am 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death 1616 Chesaco Ave. Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 164-26-2645 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1□ M 🏖 F 68 Yrs. PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 ☐ Yes 2X No 10e. Street end Number 1616 Chesaco Ave. 10f. Zip Code 21237 10g. Citizen of What Country? USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 騺 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Daniel J. Poreca 18. Mother's Name (First, Middle, Meiden Sumeme) Veronica Honusfski 19a. Informant's Name/Relationship (Type, Print) George S. Welkie Sr./husband 19b, Majling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1616 Chesaco Ave. Rosedale, MD 21237 20b. Place of Disposition (Neme of cemetery, crematory or other place) Parkwood Cemetery 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 10-8-99 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Name and Address of Facility CVach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237 enusa 23a. Part1. Enter the disease, or complications that caused the pouts. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset end Death Immediate Cause (Final 18 months. colon disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 WUnknown 1 Yes 2 No 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Was an eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medicel examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural

Physician /Medicai **Examiner**

thet the death certificate be executed

Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Director

Funeral

by

Be

Examiner

Funeral

Director

death with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Manyan Department of Health end Mental Hygiene. Important: if Ikem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mexical Examiner must be notified at

Baltimore, Maryland 21215-0020

buriel-transit end physician es the burief 98 signed by t certificate hes

in by the

Physician/Medical þ Completed Be P Certification:

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homleide

29b. Signature and title of certifier

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifies Medical

State Registra

29c. License number 016587

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Yeer)

Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name end eddress of person who completed beuse of deeth (Item 23a) (Type, Print)

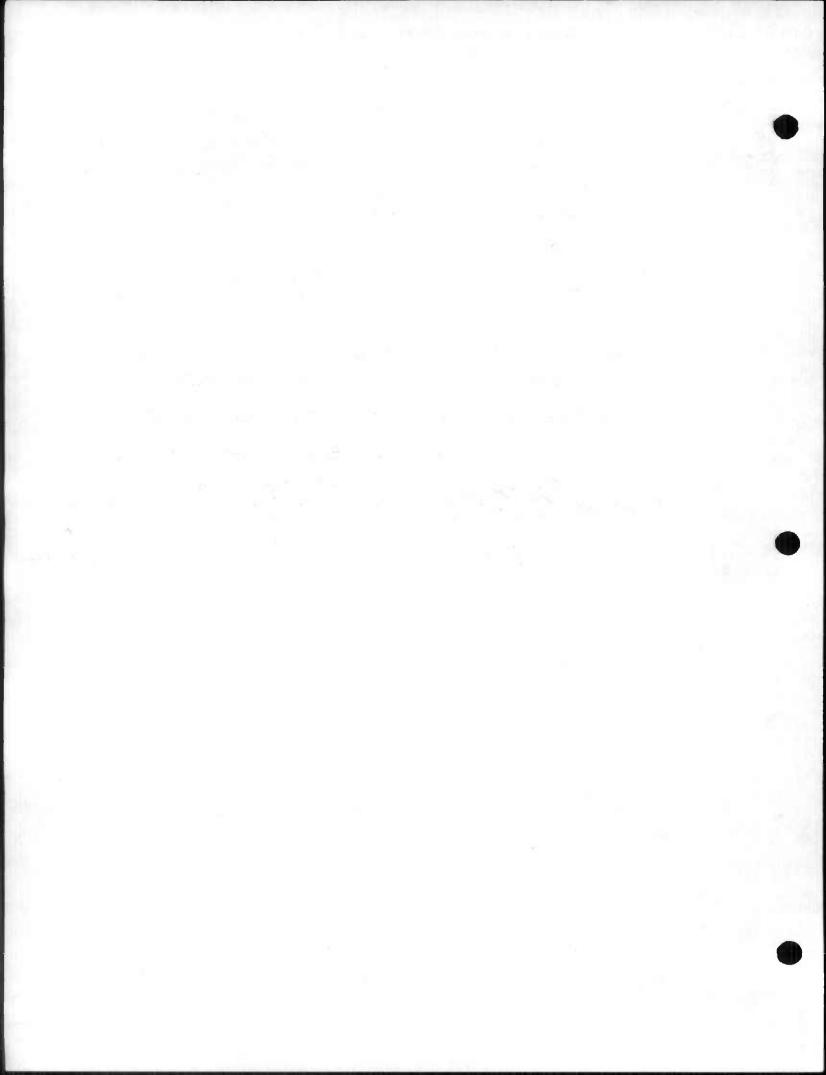
5601 Loth Raven Blody Ste 107, Batts, MO 21239 32. Registrar's Signature

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

1999

6 Could not be determined

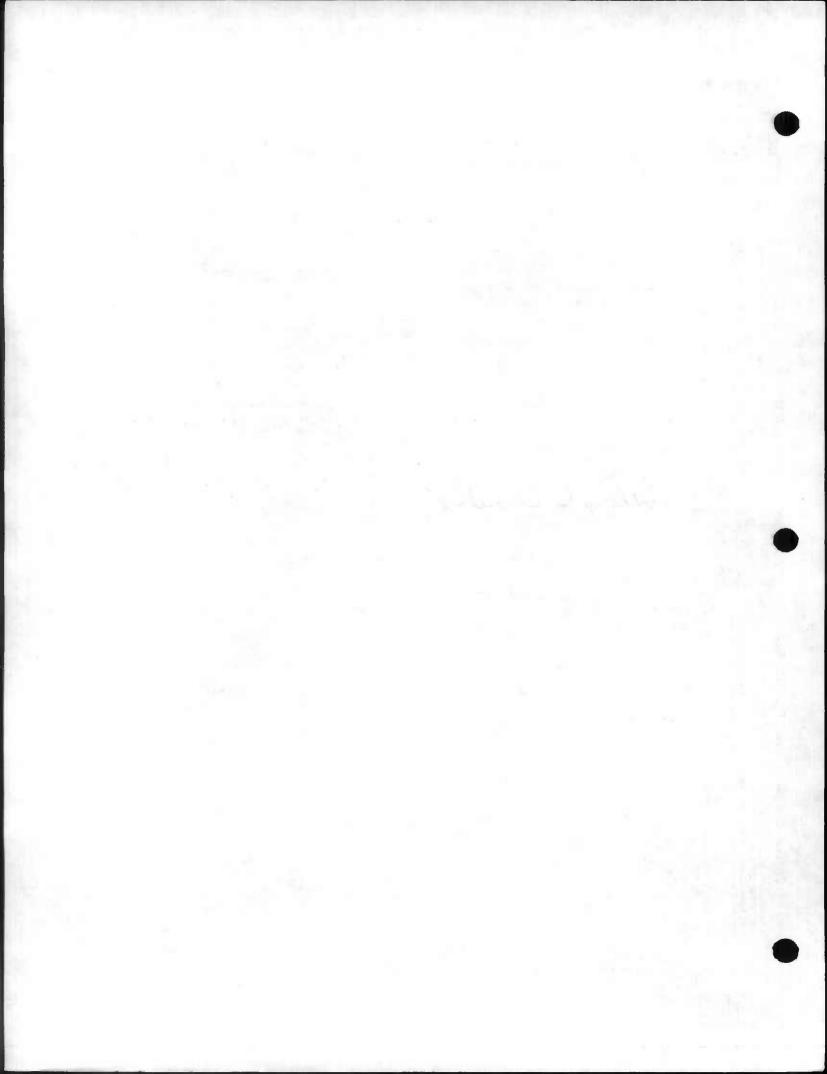
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 1999 Year October 2, Chad Brandon Zeiler 10:05 AM /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** Baltimore 7017 Lachlan Circle, Apt. E Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Days 25 Yrs. Director 217-19-3039 March 3, 1974 Spain Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shaden Baltimore 1 Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 7 Bright Oak Ct. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dales: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 Married 21215-0020 1 Yes 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) IV Technician Medical traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) . Pages 1 and 2 should be fili finent of Haalth and Mental H-tant: If item 27 is marked oth jury or other traumatic even Be Richard Zeiler Wilson Jeanie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Bright Oak Ct., Baltimore, MD 21234 Richard Zeiler (father) 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Crema 3 Removal from State permit. Page Department of Important: If any Injury or once. 5 Other (Specify) 10/5/99 Baltimore, Maryland Green Mount Crematory e of Filmeral S 21. Sig 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD Licensee 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immadiata Cause (Final Wound of Head Gunshor disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the Due to (or as a consequence of): for usa as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Were autopsy findings available prior to complation of causa of death? page 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death (Check only ona) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 SOther (Specify) Scene 2 1₽Yes 2□ No 28a. Date of Injury For 28b. Time of (Month, Day Yeer) funaral 27. Manner of Death Certification: 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural 10-2-99 subjed Sher self To the Hospital or Attendil within 24 hours after death, To the Funeral Director: A 1 Yes 2 No 1000 2 Accident in by the 3 Suicide 4 Homicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Scene 7017 Lirde, Mpt-E Lachlan 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) her stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) O. C. M. E. 10. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore Parle-Pen 111 vavid 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar



Box 68760, Division of Vital Records, P.O. Attending

LAWRENCE ADAMS

Physician LAWRENCE HENRY ADAMS /Medical 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Deeth Examiner LEONARDTOWN ST.MARY'S HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | OCT • 15, 1923 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F Yrs. Director 229-16-3648 75 Usual Rasidence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-1 shor the Medical Examiner must be notified at MECHANICSVILLE Director ST.MARY'S MARYLAND 10e. Street and Number 10f. Zip Code 20659 26650 THREE NOTCH ROAD Funeral 72 hours after death 12. Was Decadant Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give X Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 1 Navar Merriad 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: by 35 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) filed within Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 is marked other than Elementery/Secondery (0-12) College (1-4or 5+) 12 RESTAURANT/BAR OWNER 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be MATTIE BUCKLER HENRY ADAMS 2 19e. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other traugonce. 6906 CRAFTON LN. CLINTON, MD. 20735 MATTHEW SUITE-STEP BROTHER 20b. Placa of Disposition (Neme of cemalary, crematory or other placa) 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) ST.JOSEPH'S CH.CEM. 21. Signatura of Fynaral Sarvice Licansee 22. Nama and Addrass of Facility RAYMOND FUNERAL SERVICE, P.A. 23e. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** · Cardio respiratory /Medicai Immadiata Causa (Final disaasa or condition rasulting in death) Examiner The law requires that the death certificate be executed Sequantially list conditions, if eny, laading to immadiate causa. Entar Underlying Cause (Disaesa or injury that initieted avants rasulting in daath) Last Dua to (or as a consequence of) Hyperosmolar Physician/Medical Dua to (or es a consequence of): myocard: al Sepsis Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. been signed by t should be detach obe Appiration þ form child hood Completed hemiparesis certificata has Left ness Be 25. Was cesa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Sinpatient 2 □ ER/Outpatient 3 □ DOA P 1 Yas 2 No After this 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 5 Panding 1 Netural death. 1 ☐ Yas 2 ☐ No investigation 2 Accident Director: In by the 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify) or A after 4 | Homicide within 24 hours a To the Funeral C complataly filled 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et tha tima, data and place, and due to the cause(s) and mannar as stated.

2 Madical Examinar: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the tima, data and place, end due to the ceuse(s) and mannar stated. 29a. Certifiar 29b. Signatura and titla of certifier 29c. Licanse number D0051738 M.D. 30. Neme end eddrass of person who complated cause of deeth (Itam 23a) (Type, Print) 20636 DR. KAE T. AUNG HOLLYWOOD, MD. 31. Data filed (Month, Day, Year) 32. Ragistrar's Signatura State

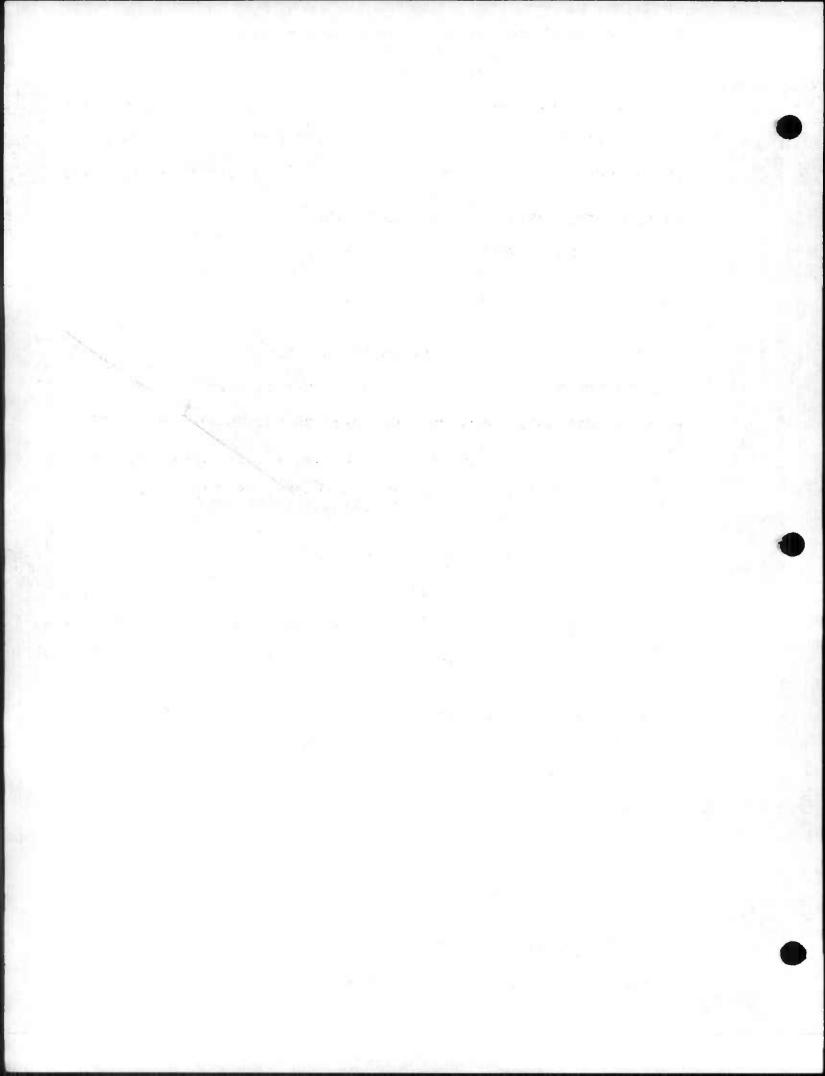
Jenen

1. Decedant's Nama (First, Middla, Last)

2. Data of Death 3. Time of Death Month Day SEPTEMBER 22, 1999 9:53PM 4c. County of Death ST. MARY'S 9. Birthplaca (Stata or Foreign MARYLAND 10d. Insida City Limits 1 Yas 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. Black, Whita, atc. Specify: WHITE 16b. Kind of Businass/Industry FOODS-SELF 20c. Location - City or Town, Stata 10-2-99 MORGANZA, MARYLAND Intarval Between Onsat and Daath 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings aveilebla prior to 24e. Was an autopsy complation of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how injury occurred 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 29d. Data signed (Month, Dey, Year)

Registrar

SEP 29 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middla, Last) Month Dey Yeer SEPTEMBER 19, 1999 **Physician** ALICE ESTELLE GILLOTT BODMER 1:30 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street and number) Examiner CUPPETT & WEEKS NURSING HOME GARRETT OAKLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept. 4, 1913 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min Yrs. 577 18 5205 86 Wash., D.C. Director Usuel Residance of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at the Mary 1 Yes 2 No Calvert Maryland Chesapeake Beach Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3712 28th Street 20732 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien 11 Maritel Status Black, White, etc. 1 Never Marriad 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3 X Widowed 4 □ Divorced permit. Pages 1 and 2 ahould be fitted within 72 hour Department of Health and Memai Phytone. Important If Item 27 is merived other the any injury or other trausers. Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 11 waitress restaurant 17. Fether's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Joseph Clarence Gillott Eva Estelle Gibbons 10 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Routa Numbar, City or Town, Stete, Zip Code) George R. Bodmer, Jr. / son P.O. Box 777, Chesapeake Beach, MD 20732 20b. Plece of Disposition (Neme of cematary, crematory or other piece 20e. Mathod of Disposition 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9-27-99 Arlington National Cem. Arlington, VA 22. Name end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 Weams mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, y ona cause on each line. 23a. Part1. Enter the disease, or or shock, or heart feilure/ List or Onset end Daeth **Physician** Immediate Ceuse (Finel disease or condition rasulting in death) /Medical acute ischemic stroke Examiner 2 days Dua to (or as a consequanca of): Examiner certificate be executed attending physician end for use es the bunat-trans Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Lest Dua to (or es e consequença of) Physician/Medicai Due to (or es e consequence of) Se P.0. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the undarlying cause given in Pert I. 2 1 Yes 2 No 3 Probably 4 Unknown atrial frillation; coronary artery disease by Division of Vital Records, with angina and congestive heart failure; 24b. Wara eutopsy findings eveileble prior to completion of cause of daath? 24a. Wes en eutopsy performed? Completed COPD; glaucome; prior stroke certificate has 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case raferrad to medical exeminer? Be 26. Place of Daath (Check only ona) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at & Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Naturel
Accident 5 Panding s efter death. 1 Yes 2 No investigation 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital of 24 hours events of Funeral D Certifying Physician: To tha best of my knowledga, daath occurred et the time, date end pleca, end due to the cause(s) end mennar es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifian Medical completely (Check only one) To the P within 2 29c. License number 29d. Date signed (Month, Day, Year) D26650 9/19/1999 30. Name and address of purson who completed cause of daath (Item 23a) (Type, Print)

Registrar

M.D. 13079 Garrett Hghwy; Oakland, Md 21550 Margaret Kaiser, SEP 2 3 1999

The state of the s

Albertson, Sidney more. Maryland 21215-0020

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 2. Dete of Death 1. Decedent's Name (First Middle Last) **Physician** Month Vear SIDNEY ALFRED CULBERTSON /Medicai SEPTEMBER 23 1999 01:12 AM 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER
5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year 8. Date of Birth (Month, Day, Yeer) 2 / 18 / 1915 9. Birthpleca (State or Foreign **Funeral** 1**∑**M 2□ F Days 84 Yrs PENNSYLVANIA 178-09-8457 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director CARROLL WESTMINSTER MD. 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ŏ items 23a MARK WAY, APT. 300 21158 205 ST. USA 12. Was Decedent Ever in U,S Armed Forces? 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) IXYes 2 □ No IfYes, Give Year or Dates: WW II 1 ☐ Never Married 2X Married ò 1 ☐ Yes 2X No Specify Specify: WHITE þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exercise. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry FEDERAL Etementery/Secondary (0-12) College (1-4or 5+) EDUCATIONAL SPECIALIST GOVERNMENT 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) CHARLES H. CULBERTSON ESTHER MAE McCLOSKEY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) WIFE MARGARET H. CULBERTSON 205 ST. MARK WAY, APT. 300, Westminster, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/25/99 WESTMINSTER, MD. MEADOW BRANCH CEM. 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final Ruptured Suprarenal Aortic Aneurysm disease or condition resulting in death) Aneurysm Sequentially list conditions, if eny, teading to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting In death) Last and Box 68760 ypertension
Thue to (or as a consequence of): Physician/Medicai the Artery oronary Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of desth? 1 Tyes 2 No 3 Probably 4 Dunknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menne of Deeth 28b. Time of Medicai Certification: 28a. Date of Injury (Month. Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) end menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25349 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Golneke M.D. 6565 N. Charles St. Suite 605 Towson, Md. 21204

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

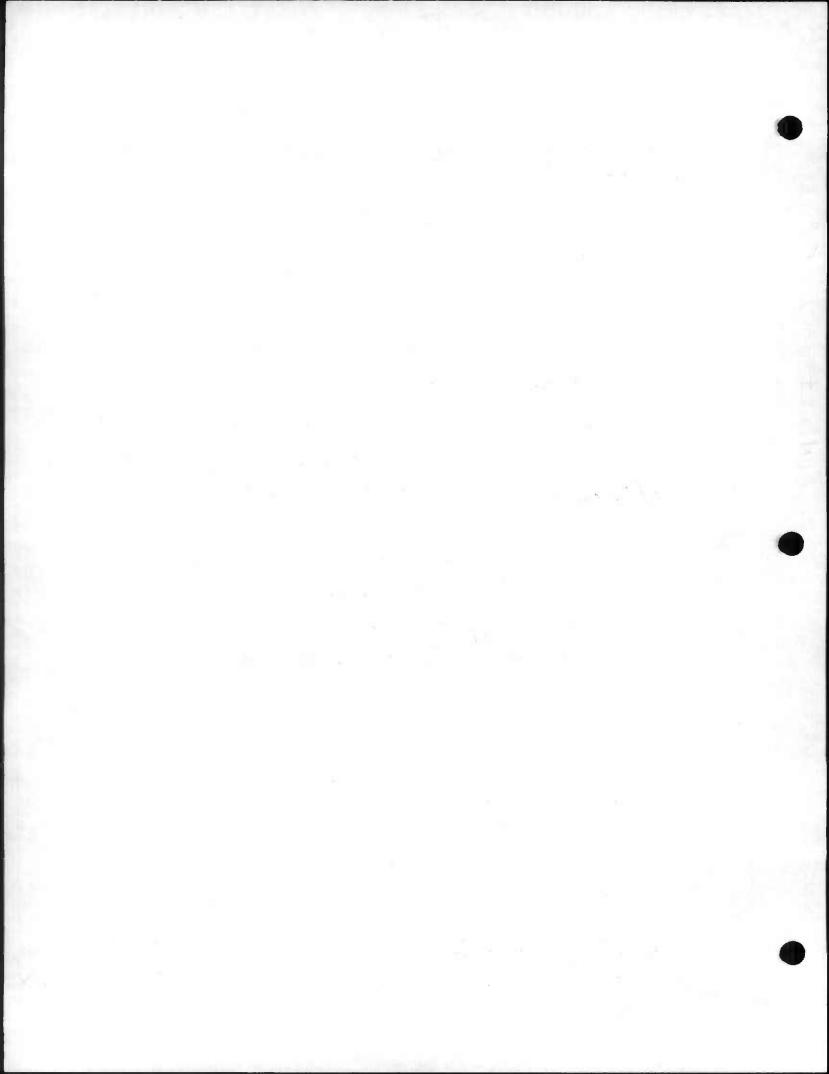
State

Registrar

Peter J. Go 31. Date filed (Month, Day, Year)

SEP 2 7 1999

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene PER MEO G776 10-16-99 Certificate of Death AMEND ITEM: #5 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** AARON COATES SEPTEMBER 24, 1999 17:30 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months Days Hours Min. Oct. 21, 1939 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) 59 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 219573635915 Usual Residence of Decedent Maryland Director permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mentel Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Magical Experime must be notified anone. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1393 Tyler Avenue 21403 USA Funerai 12, Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕱 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 ☐ Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Farming Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aaron E. Coates, Sr. Martha Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mildred Coates/Wife 13 D Marcs Court Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ernestine Jones Cemetery9/30/99 Chesapeake Beach, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funerel Service Licensee 9 Sers 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Finel NECK CARCINGAT disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as e consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by I 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? s pluods Completed 24a. Was an autopsy hes 16 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After this 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation after death
Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di-completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated. edical 29e. Certifier 29b. Signature and this of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26358 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 100 Hospital Road, Prince Frederick, MD 20678 H. Weigel, 32. Registrer's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

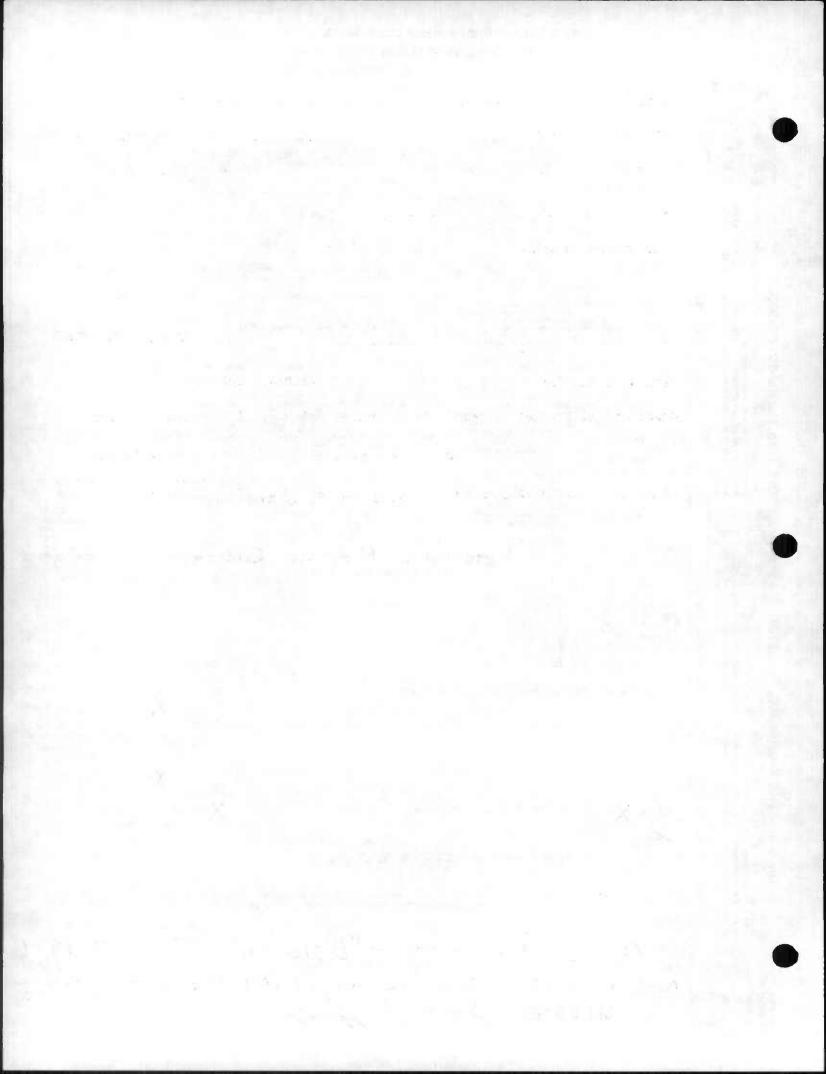
Registrar

SEP 2 7 1999

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 3 1625

Physic		1. Decedent's Name			n! .1.7				2. Date of Do	D	ay	Year	3. Time of Deeth
/Medi		Stefan			Eichler				Sept	27	199		3:05am
Exami	ner	45 City Town of Co.									c. County of		
Funeral Director		5. Social Security N 215-42-05	533	6. Sex 1 M 2 □ F	7. Age (In yr. 85	s. lest birthday) Yrs.	If Under 1 Yes Months Days		8. Date of Bi (Month, D Sept 1	irth ey, Year 19	14	9. Birthi Cour Pola	
Marylend Fed at	tor	Usual Residence of 10a. State MCI	10b. County Carr			city, Town or Lo dersbur						1	10d. Inside City Limit
Mith the	Funeral Director	10e. Street and Nun 1625 Hea		leights			10f. Zip Code 21784		LVE		itizen of W USA	/hat Cou	ntry?
within 72 hours eans. then "neturel", one worked Exer		11. Meritel Status 1 Never Marri 3 Widowed		Armed 1 ☐ Yes	cedent Ever in Forces? 2X No Give Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp ban, Mexicen, Puerto Specify:	pecify Yes or N Rican, etc.)	0-	Black	- Americk, White,	
		(Spec	ify only highe	nt's Education est grade complete College	d) (1-4or 5+)	(Give	dent's Usual Occi kind of work don DO NOT use retir plogist	supation ne during most of working ired)		16b. Kind of Business/Indu State of Mar			
snould be filed and Mentel Hygis marked other umatic event, ti	To Be C	17. Father's Name (M. :	18. Mother's Nam Wieslava			n Sumem	е)	
i end 2 shou Health end M em 27 ie mer other traumet		19a. Informant's Na Lieselott			spouse)			Heights,					
permit. Pages 1 end Department of Health Important: If item 27 any injury or other ti once.		20e. Method of Disp 1 XBurial 2 (4 Donation	Cremation	3 □Removal from	on Ctate	cemetery, cre	osition (Neme of metory or other pl 7 Memoria		Date -30-99		Location -		own, State
Department of Important: If any injury or once.		21. Signature of Fur		Licensee ght He	bert		2. Name and Add O. Box 1	ress of Facility Ha 95 Sykesv				me &	Chapel
hysician		23e. Pert1. Enter the shock, or hear	he disease, o rt failure. Lis	r complications that t only one cause or	t ceused the de n eech tine.	eth. Do not en	ter the mode of dy	ring, such as cerdiac	or respiretory	errest,			Approximate tnterval Between Onset and Death
/Medical examiner		Immediate Cause (disease or condition resulting in death)	(Final n	a. M	John et	-1.	0)				20
* *	ne					(or as a conse		tate (anci	24			20 year
	Medicai Examiner	Sequentially list con if eny, leading to im ceuse. Enter Unde Cause (Disease or that initiated events resulting in death) I.	3	b	Due to		quence of):	fate (enci				Hyea e
y the attending	edicai	Sequentially list con if eny, leading to im ceuse. Enter Unde Cause (Diseese or that initiated events	Last	c	Due to	(or as a consector as	quence of): quence of):		23b. Dic	d tobacc		ntribute t	to the cause of deaf
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rnystician: The taw requires that the operin certificity this certificete has been signed by the attending ral director, page 2 should be detached for use a	Medical Certification: To Be Completed by Physician/Medical	Sequentially list con if eny, leading to im ceuse. Enter Unde Cause (Disease or that initiated events resulting in death) I. Pert II. Other signiff 25. Wes cese refer examiner? 1 Yes 27. Manner of Death Neturel 2 Accident 3 Suicide 4 Homlcide	red to medice No 1 Could detern Certifying Certifies title of certifies	d. d. d. d. d. d. d. d. d. d.	Due to Due to Due to Due to Due to Due to Due to Due to	(or as a consection of a consection of a conse	quence of): quence of): quence of): quence of): inderlying ceuse g inderlying ceuse g M 28c. Inj W M 11 reet, factory, office th occurred at the evestigation, in my	26. Place of Dea wher: 4 \(\text{Nursing H} \) ury at ork? \(\text{Yes} \) 2 \(\text{No} \) etime, dete end place	23b. Did 1	d tobacc Yes s an autorimed? Yes one) sidence s how inj (Street own, Sta	No use con 22 No opsy No opsy No 8 Other occurred Number occurred (s) and mand place, a	24b. Ward of the second of the	to the cause of deat beably 4 Unkno Vere eutopsy findings vailable prior to ompletion of ceuse I death? Yes 2 No ify) rel Route Number, stated. to the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #1, Per Phy. 9/28/99, Carroll County, wjl Certificate of Death 2. Dete of Deeth Month ROBERT L. ERB 24 4e. Facility Neme (If not institution, give street and number)

If Under 1 Yeer

10f. Zip Code

Days

21204

TOWSON

7. Aga (In yrs. last birthday)

Yrs.

10c. City, Town or Location

Towson

6. Sex 1 M 2 □ F

4b. City, Town, or Location of Deeth

If Under 24 Hrs.

OW SON

4c. County of De

10g. Citizen of Whet Country?

USA

CALTIMORE

Birthpleca (State or Foreign Country)
 MD

10d. Inside City Limits

1 Yas 2 No

Physician /Medical **Examiner**

MANOR ociel Security Number

10b. County

Baltimore

509 E.Joppa Rd.

220-40-8601

10a. State

neral Director

MD

10e. Street end Number

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mantal Hygiane. Important: if item 27 is marked other than "natural", or harm-named in traumatic events.

Physicia /Medica Examine

To the Hospital or Attanding Physician: The law requires that the death cartificate be assected within 24 hours after death.

To the Funeral Director: After this cartificate hes been signed by the ettending physician and completaly filled in by the funeral director, page 2 should be deteched for use as the bunal-trensit

Division of Vital Records, P.O. Box 68760,

by Fune	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Detes:	13. Was Dacedant of If Yes, specify Cu	Hispenic Origin? (Specify Yeban, Mexicen, Puerto Rican, Specify:	es or No- atc.) 14. Ra Bla Specia	ce-American Indian, ack, White, etc. by: White
Be Completed	15. Decedent's Edi (Specify only highest grad	de complated)	16e. Decedent's Usuel Occ (Give kind of work don life. DO NOT use reti	upation e during most of working ed)	16b. Kind of E	Business/Industry
E	Elementary/Secondary (0-12)	College (1-4or 5+)	Laborer	,	Dome	estic
To Be C	17. Fethar's Name (First, Middla, Last) Russell Erb			18. Mother's Name (First, Luella All		me)
-	19e. informent's Neme/Relationship (T	ype, Print)	19b. Meiling Address (Stre	et and Number or Rural Route	e Number, City or Town	, State, Zip Code)
	Helen Jewell-Sist	ter	3541 Halter	Rd.Westminst	er,MD21158	
	20e. Mathod of Disposition 1 □ Burial 2 □ Cremation 3 □ I 4 □ Donetion 5 □ Other (Specify,	Removel from State	nce of Disposition (Name of metery, cramatory or other percentage).			- City or Town, State
	21. Signeture of Funeral Service Licens	I Little (22. Name end Add	rass of Facility F.H.34 Maple	Ave.Little	estown, PA17340
	23e. Pert I. Enter the disease, or com- shock, or heert feilure. List only d Immediate Ceuse (Final disease or condition resulting in deeth)	lications that caused the distribute ceuse on each line.	Do not entar the mode of d	ring, such es cerdiac or respi	retory errest,	Approximete Interval Between Onset end Deeth
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or Injury thet initieted events resulting in deeth) Lest	Seizur	as e consequence of):	vdor	,	>Tykor >Tykor
y Physicia	Part II. Other significant conditions con	ntributing to death but not resulti	ing in the underlying cause g	iven In Pert I. 23	8b. Did tobacco use co	ontribute to the cause of death? 3 Probably Wunknown
Completed by				24	e. Wes en eutopsy performed?	24b. Were eutopsy findings evelleble prior to completion of causa of death?
NO.					1 ☐ Yes 20 No	1 ☐ Yes 20 No
Be	25. Wes cese referred to medical exeminer?			26. Place of Deeth (Chec	k only one)	
tification: To	1 Yes 2 No 27. Manner of Deeth 1 Nature 5 Pending 2 Accident Investigation		8b. Time of Injury 28c. Inj	ther: 4 Nursing Home 5 ury et ork? 28d. De	☐ Residence 6 ☐Othescribe how Injury occur	
Ce	3 Suicide 6 Could not be determined	28e. Plece of Injury - At home building, etc. (Specify)	e, ferm, street, fectory, office	0.4	cation (Straat and Numl y or Town, State)	ber or Rural Routa Number,
edical	29e. Certifier (Check only one) 2 Medical Exemi	eiclan: To the best of my knowle neer On the basis of other name and manneystates.	deeth occurred et the in and/or investigetion, in my	ime, date end plece, end due opinion, deeth occurred et th	e to the ceuse(s) end me e time, dete end piece,	enner es steted. end due to tha cause(s)
Σ	29b. Signature end title of certifie		134	2736	29d. Data signe	od (Month, Day, Yaar) 4 - 99
	30. Name end eddress of perper who co	empleted cause of deeth (Item 2)	3e) (Type, Print)			

G. Sparks

State Registrar

SEP 28 1999

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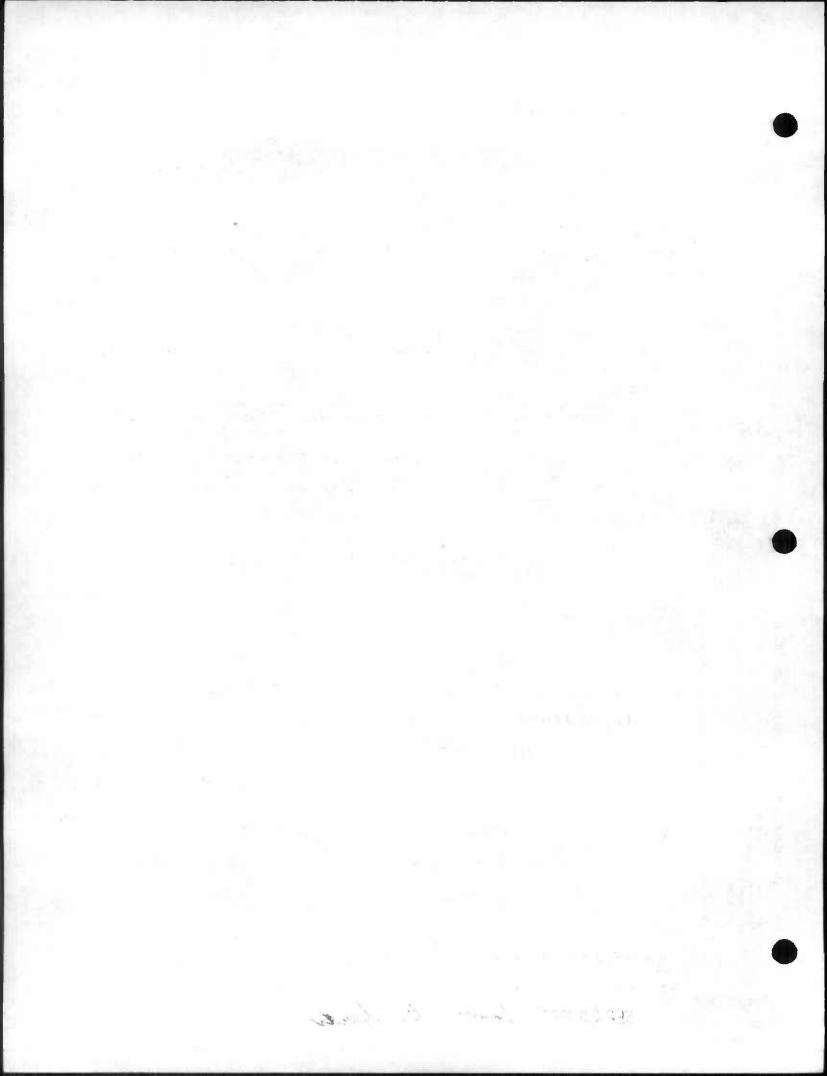
99-5674-033 jhm SALLY ANN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	FASSIO		•	Cei	rtificate of	Death	Re	g. No.	9.10	(m. 1
		1. Decedent's Name (First, Middle, La	st)				2. Data of Death Month	h	Year 3.	Time of Death
	Physician /Medical	Sally Ann E	assio				SEPTEMB			9:05 PM
	Examiner	4a Facility Name (If not institution, giv	re street and number)			4b. City, Town, or Lo	ocation of Death	4c. County		
		12703 LUNAN ROA	D			Clinton		PRINC	E GEOR	GES
	Funeral	Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Data of Birth (Month, Day,	Year)	9. Birthplace	
в	Director	217-60-7040	50	Yrs.			Sept 1,	1949	Marylár	nd
	2	Ususl Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				104 [neide City I imite
	Anyth and and or									
	with the Marylan a or 28a-f show be notified at Director	MD P.G.		linton	10f. Zip Code		14	25		
	The party				207	0.5				
	ther death with the Maryland r here 23a or 28ef show niner must be notified at Furneral Director	12703 Lunan Roa	12. Was Decedent Ever	nIIS 13 1						ndian
_		1 Never Married 210 Married	Armed Forces?	10.0	f Yes, specify Cul	Hispanic Origin? (Sp pan, Mexican, Puerto	Rican, etc.)			reason r ₄
20	ar, or		If Yes, Give Year or Datas:		1□ Yes XX No	Specify:		Specify	. V	White
ĕ			ducation	16a. Deced	dent's Usual Occu	pation	1	16b. Kind of Br		
215	ed within 72 ho ygiens. Ar then "netur t, the Medical. Completed	(Specify only highest gra Elementary/Secondary (0-12)	college (1-4or 5+)	(Give	kind of work done DO NOT use retin	during most of work ad)	ring			
2	d with the second	12	COIIOGO (1-401 54)	Clerk	2			Retail	Sales	
멀	eres a	17. Father's Nama (First, Middle, Last,)			18. Mothar's Nam	a (First, Middle, N	Aaiden Suman	10)	
/la	De 2 2 0	John Burroughs	5			Annie S	weeny			
Maryland 21215-0020	2 shot vand A la man	19a. Informant's Name/Ralationship (fa)
	and and a	Jim Fassio (HUSI	BAND)	12703	3 Lunan 1	Road, Clir	iton, Mai	cyland	20/35	
ore	- FE5	20a Method of Disposition 1 Burial 2 Cremation 3		 b. Place of Dispo cematary, crer 	sition (Name of natory or other pla	ace)	Date 2	20c. Location -	City or Town,	State
Ĕ	Pages nent of ant: if the ury or o	4 □ Donation 5 □ Other (Specif	y) State	st. Thoma	as Episc	opal Cemet				
Baltimore,	mil. ports	21. Signature of Funaral Sarvice Licer	1500							
0	881108	1 5th 9 5	#_	A.	Lexandri	a Ferry Ro	oad, Clir	nton, M	D 2073	5
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	leath. Do not ent	ar tha mode of dy	ing, such as cardiac	or raspiratory arre	est,	App	oroximata
Š	Physician	Silver, or itear failure. Elst only	OND COUSE ON EQUITING.							
v di	/Medical	Immediate Cause (Finat disease or condition	(0	rebral	ho	morcha	168			
П	Examiner	resulting in death)		o (or as a consec		11 0 11 110	7			
	P # E		h							
	death certificate be assecuted a stending physician and of for use as the burial-transit sician/Medical Examines	Sequentially list conditions,	Dua t	o (or as a conseq	uence of):					200
60,	cian couries	Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or injury	c							
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	ding g		d							
Box	at the death certificate be 1 by the attending physicis etached for use as the bu Physician/Medical									
o	signed by the a lid be detached if	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause g	iven in Part I.	23b. Dld 1o	BER 20, 1999 19:05 PM 4c. County of Death		
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Records,	signe d be d		nsion				24a Was as	n nistanna.	24h Were I	utoney findings
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360	has t								of deat	h?
	cate ha						1,2 Ye	s 2 No	1 2 Ye	s 2 No
of VItal	Physician: The rbis certificate and director, page 1: To Be Co	25. Was casa refarred to medicat examinar?	Hospitat:		10		th (Check only one			
ot	Plant T	1 XYas 2 No 27. Manner of Death	1 LI Inpatient	2 ER/Outpatien	I JLI DUA	4 LI Nursing Ho				SCENE
2	5 4 5 0	1 Naturat 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Tima of Injury	We	ork? Yes 2 No	28d. Describe no	w injury occur	red	
100	Attending in death. Sctor: After by the fune liftcation	2 Accident investigation 3 Suicide 6 Could not b		t home form ste			29f Location (St	reat and Numb	or or Pural Do	uto Alumbar
Division	to a factor and a star death. In a Director: After the line of in by the funeration: Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	Bot, factory, office		City or Town		or or ribrarrio	olo Ivamber,
_	Surse in the course of the cou	29a. Certifier 1☐ Certifying Ph	veicien: To the best of my	knowledge deeth	occurred at the t	ime date and place	and due to the ce	uea/s) and me	anner es etetor	
	in 24 hours in 24 hour he Funer pletely fill edical									
	To the Hospital or Attendi within 24 hours after death. You the Funeral Director: A completely filled in by the it Medical Certificati	29b. Signature and title of certifier			29c. Licen	se number	25	9d. Date signe	d (Month, Day,	Year)
	- > - 0	11.11	A 1/1 -1 -	12	00	/IP	100			
		30. Name and address of person who	1 V LOCA	M		TE .	32	PELITMB	ER ZI,	1999
						of Delt	- Ac		21201	
	State	Stephen S, 1 31. Data filed (Month, Day, Year)	32. Registrar's Si	gnature p			more, Ma	патара	21201	
	Registrar	SEP 2 3 199		B.	Sport					



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				State of	iviai yiai				Death			1.3	1528	
п	Physici	an	1. Decedent's Name <i>(First, Middl</i> e, Alverta	Last)		Gros	ss					Year 1000	3. Tima of Deeth	
	/Medi Examir	cal	4a. Fecility Neme (If not institution, Bayside Nurs						4b. City, Town, or L Lexingtor	ocation of Death	4c. County	of Death		
	Funeral Director				Aga (in yrs	. last birthday 5 Yrs.	Month	der 1 Year ns Deys	if Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day March 4				
	pue,		Usuei Residence of Dacedant 10a. Stete 10b. County		10c. C	ity, Town or I	ocation					10	Od. insida City Limits	
	Mery Mery	ţoţ	Maryland St. Ma	ary's		Valley	Lee						1 ☐ Yes 2 No	
	th with the 23a or 28	Funeral Director	10e. Street and Number 44988 Hewitt Ro	oad		10f. Zip Code 20692				1	0g. Citizen of V USA	Vhat Coun	try?	
21215-0020	s 1 and 2 should be filed within 72 hours efter death with the Maryland if Heelth and Mental Hygiene. If Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Experimet must be notified at	þ	11. Marital Status 1 Navar Married 2 Merrie 3 Widowed 4 Divorced	12. Was Deceding Armed Force of 1 Tags 2 If Yes, Given Yeer or Detection	es? [∡No	J,S. 13		cedent of F pecify Cubi 2 No	lispenic Origin? (Sp an, Maxican, Puarto Specify:	September 26, 1999 11:25 A.M. or Location of Death ton Park 4c. County of Death St. Mary's Hrs. 8. Deta of Birth (Month, Day, Year) 904 March 4, 1904 March 10d. inside City Limits 1 Yes 25 No 10g. Citizen of What Country? USA 7 (Specify Yas or No- uarto Rican, atc.) 14. Race - American Indien, Bleck, White, atc. Specify: Black Working 16b. Kind of Business/Industry Someone else's house Neme (First, Middle, Meiden Surmema) Starks or Flural Route Number, City or Town, Steta, Zip Code) Sunderland, MD 20689 Dete 20c. Location - City or Town, State 9/29/99 Lothian, MD Sewell Funeral Home Rd. Prince Frederick, MD 20678 rdiec or respiretory errast, Indienyal Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? 1 Yes 2 100 1 Yes 2 No Deeth (Check only one) ng Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred				
15-0	netur	eted	15. Decedent's (Specify only highest	Education grade completed)		16e. Dec	edent's U a kind of	suel Occup work dona	petion during most of work d)	vorking 16b. Kind of		usiness/Ind	lustry	
2121	filed within Hygiene. Ither than ent, the Me	Completed	Elementary/Secondary (0-12)	Coilege (1-4	or 5+)	life.		ruse retire Stic	d)		Someone	else	's house	
	e filed al Hygie other vent, p	Be C	17. Fether's Nema (First, Middle, Li	ast)		•			18. Mother's Nem	e (First, Middle, I	Melden Sumen	na)		
Maryland	2 should be end Mentel is marked o	To	James		Star				Susan		Starks			
Mar	end 2 sh selth end n 27 is m		19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, Company)										Code)	
re,	of Heelth of Heelth I item 27 r other tr		20e. Method of Disposition		20b.	Piece of Disp cemetery, cr							wn, State	
imo	Pag nent int: Ii		1 Burlel 2 Cremation 3 4 Donetion 5 Other (Spe		ere	oses ()	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funerel Service Li	censee Sevel	0								, MD 20678	
Box 68760,	death certificate be executed with the standing physician and addresses the burnel-transit.	Physician/Medical Examiner	shock, or heeft teilure. List of the disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest	b. Ca	Due to (organ a consi can or as a conse can or as a conse	equence of	man al	gtan Farli	fire 1918 DE	7	000	Interval Between Onset and Death	
.O. E	the att	ysici	Part II. Other significant condition	contributing to deat	h but not re	sulting In tha	underlyin	g cause giv	ven in Pert I.	23b. Dld to	bacco use co	ntribute to	the cause of death?	
s, P.	es that the de igned by the a be deteched to	by Ph								1 U Y	2 XVO	3 Prob	ably 4 Unknown	
Record	e lew requir hes been s ge 2 should	Completed b								perform	med?	cor of o	elleble prior to mpletion of cause death?	
Vital		Be C	25. Wes case referred to medical examiner?						28. Place of Deer				7100 2010	
of V	Q 00 Z	은	1 ☐ Yas 210 No	Hospitel: 1 Inp		ER/Outpatie		DOA Oth	4 De Nursing Ho				()	
	une une	tion	27. Manner of Deeth 1 Neturel 5 ☐ Pending 2 ☐ Accident invastiga		Day Year)	28b. Time injury		28c. Injui Woo	ryet rk? Yas 2 □ No	28d. Describe ho	w injury occur	red		
Division	i or Attending efter death. Director: After d in by the fune	Certification:	3 Suicida 6 Could no determin	ot be 28e. Pieca of	Injury - At h , etc. (Speci		treet, fect					er or Rura	I Route Number,	
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Medical Ex	Physician: To the be xaminer: On the basi	s of exemine	owledge, dee etion end/or I	th occurrences	ed et the tir	me, dete end plece, ppinion, deeth occur	end due to the cred at the time, d	euse(s) end me ete end plece,	enner es st and dua to	eted. the cause(s)	
	To the vithin 2 To the comple	×	29b. Signeture and litle of certifier	Dhel		111	1	29c. Licens	se number	1	9d. Date signe	d (Month, I	Day Year)	
			30. Neme end address of person w	ho completed cause	of deeth (He	m 23a) (Tune	Print)	1	TTU		110	111	/	
	3		James P. Jarbo	/ /				Notch	n Rd. Holi	lywood,	MD 2063	16		
	Sta Registr	_	31. Dete filed (Month, Dey, Year)	V	istrer's Sign	eture &	4	bout	2					

DHMH 16 Rev 6/95

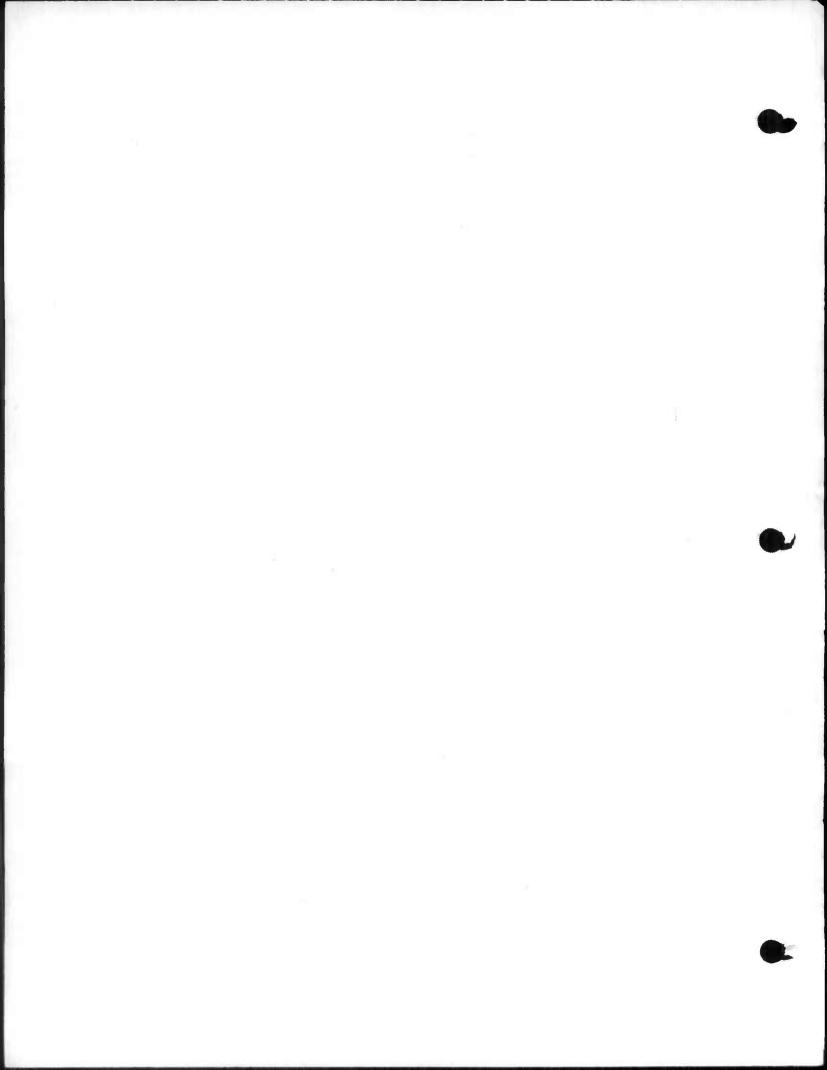
41 444 4 or the color of th .

BALLIMORE, MARILAND ZIZIS-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Memfal Hygiene prior to burial, cremation, or removal.
THE STATE OF THE S	TO THE HOSPITAL OR ATTENDING PHYSICIAN! The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the I be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTA	HYGIEN	E		
į	1. DECEDENT'S NAME (First, Middle, Last)	BERNICE M	IARGARET	г намр	SON	2. DATE MONTI Sep	t. 20	, 195	59	3. TIME OF DEATH 1:56 p m
	4. SOCIAL SECURITY NUMBER 213-46-2816	1 M 2X F	In yrs. lest birthdey) The state of the sta	IF UNDER 1 YEAR MONTHS DAYE	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont) Mar	OF BURTH 1, 00%, 1194		BIRTHP Country) ary	LACE (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give str Washington Advent RESIDENCE OF DECEMENT		L		a Park	EATH		9c. COUNTY Montg		
DIRECTOR	10a. STATE 10b. COUNTY	lerick		mmitsbu						IOd. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	410 West Lincoln A	ve., Apt. 23	30	101	21727					IAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2X NO	If yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Y If yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 YES 2 NO Specify:			Black, White, etc.		White, etc.
COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)	16a. DECEDENT'S (Give kind of w life. Do NOT use Secret	rork done during mo e retired.)	DN st of working	16b.	KIND OF BUS		RY		
	17. FATHER'S NAME (First, Middle, Last)	Hampgon	Decret	car y	18. MOTHER'S NA			Sumame)		
TO BE	Robert E. 19a. INFORMANT'S NAME (Type/Print) Robert E. Hampson,	= 2	19b. MAILING	ADDRESS (Street a	nd Number or Rural I Wn Pike,	Route Numb	er, City or Town	, State, Zip Co-		727
	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE O	F DISPOSITION (Na	me of	DATI	20c. LOC	CATION — City	or Town	
	4 Donation 5 Wither (Specify) Ent 21. SIGNATURE OF FUNERAL SERVICE LICE		etery, cremetory or ot Resthaver	22. NAME AN	D ADDRESS OF FA	CILITY		Funer	al	
M00534 136 E. Baltimore St., Taneytown, MD 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, [A]										
	snock, or haert tallure. List only one cause on each line. Intervsi Between Onset and Death									
CERTIFICATION	disease or condition resulting in death) Due to (or as a consequence of): Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of):									
MEDICAL C	PART II. Other significant conditions	contributing to deeth be	ut not resulting in	n the underlying	cause given in	Part i.	24a. WAS AN PERFORE	MED?	A	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAIN	V 🗷			1	YES 2 NO
PHYSICIAN:		HOSPITAL:		OTHER:	s 5 🗆 Rasidence	6 □ Other	(Specify)			
	27. MANNER OF DEATH 1 Metural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJ	URY AT RK?		CRIBE HOW IN	JURY OCCUR	ED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, st			28f. LOCA	ATION (Street as or Town, State)	nd Number or F	lural Rou	ite Number,
COMPLETE		IAN: To the best of my knowlers							inae(a) 1	and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	Doons			29c. LICENSE NUM	BER 3		29d, DATE SI	SNED (A	Month, Day, Year)
	DR. ANJUM G.	QAZi	106 9	Print)	StNU	Uts	08 /	Vast.	D	.C. 20010
	SEP 2 4 1999	Se REGISTRAR'S SIGNA		Soone	1					

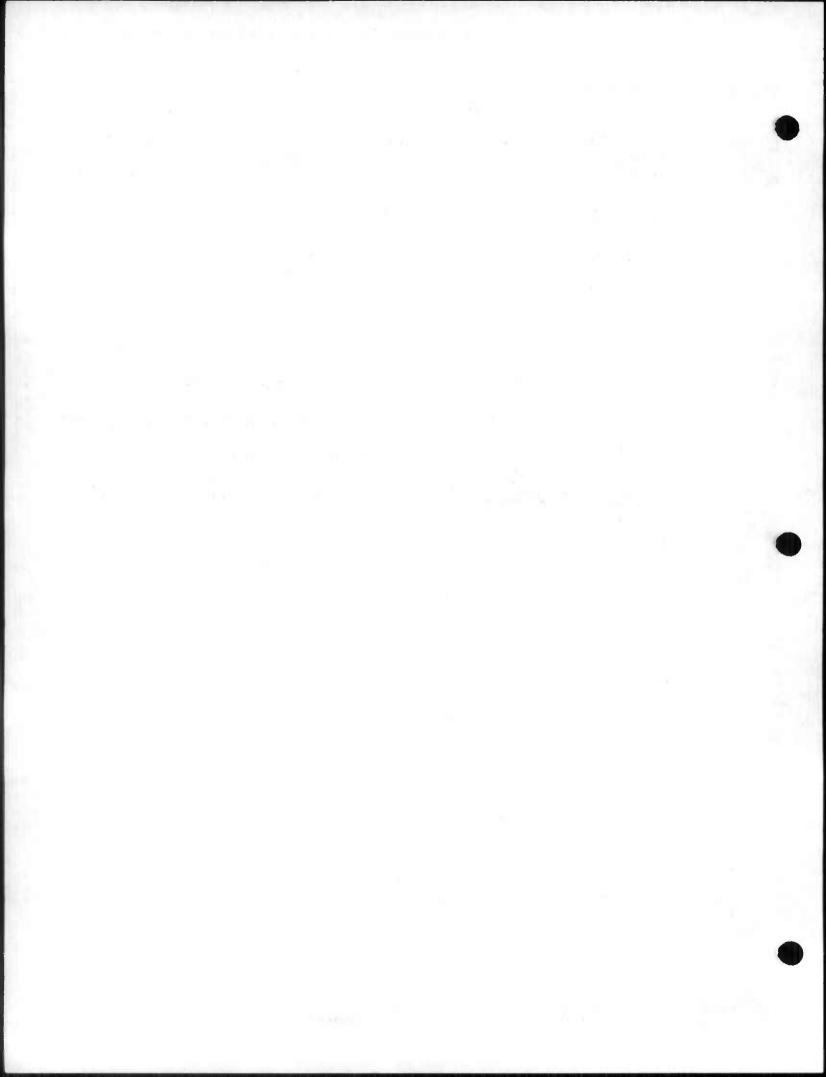




1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 46 JOHN THOMAS HUNT 24 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) 3 / 7 / 1 9 4 3 Birthplece (State or Foreign Country)
 MARYLAND **Funeral** Months Hours MOM 2□ F 215-40-2008 56 Director Usuet Residence of Decedent filed within 72 hours efter deeth with the Maryland Hygiene. 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ism 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Modical Experience result be notified at MD. CARROLL WESTMINSTER 1X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 105 E. GREEN ST. 21157 USA. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Merried 2 M Married Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: if itam 27 is marked other than any injury or other trainment. Elementary/Secondery (0-12) College (1-4or 5+) FIRE FIGHTER FIRE DEPARTMENT 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) JOHN HUNT JR. GERALDINE VIRGINIA CARTER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SHARON L. HUNT 105 E. GREEN ST., WESTMINSTER, MD. 21157 20b. Plece of Dispositton (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 9/28/99 BALTIMORE, MD. 21. Signature of Funeral Service Ligenses 22. Name end Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximete ntervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) CARDIAC ARRHYTHMIA Examiner MINUTER Due to (or es e consequence of): Due to (or as e consequence of): The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue Box 68760 nding physician Physician/Medical 176 Due to (or as e consequence of): USB BS for u P.O. I Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown CHRONIC RENAL FAILURE Records, þ 8 24b. Were autopsy findings aveilebie prior to completion of cause of death? page 2 should Completed 24a. Wes en eutopsy performed? peed HEART FRILURE CONLESTINE hes 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No this certificete Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funaral Diractor: After this certifice completely filled in by the funeral director, p. 25. Wes cese referred to medicel exeminer? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homictde 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

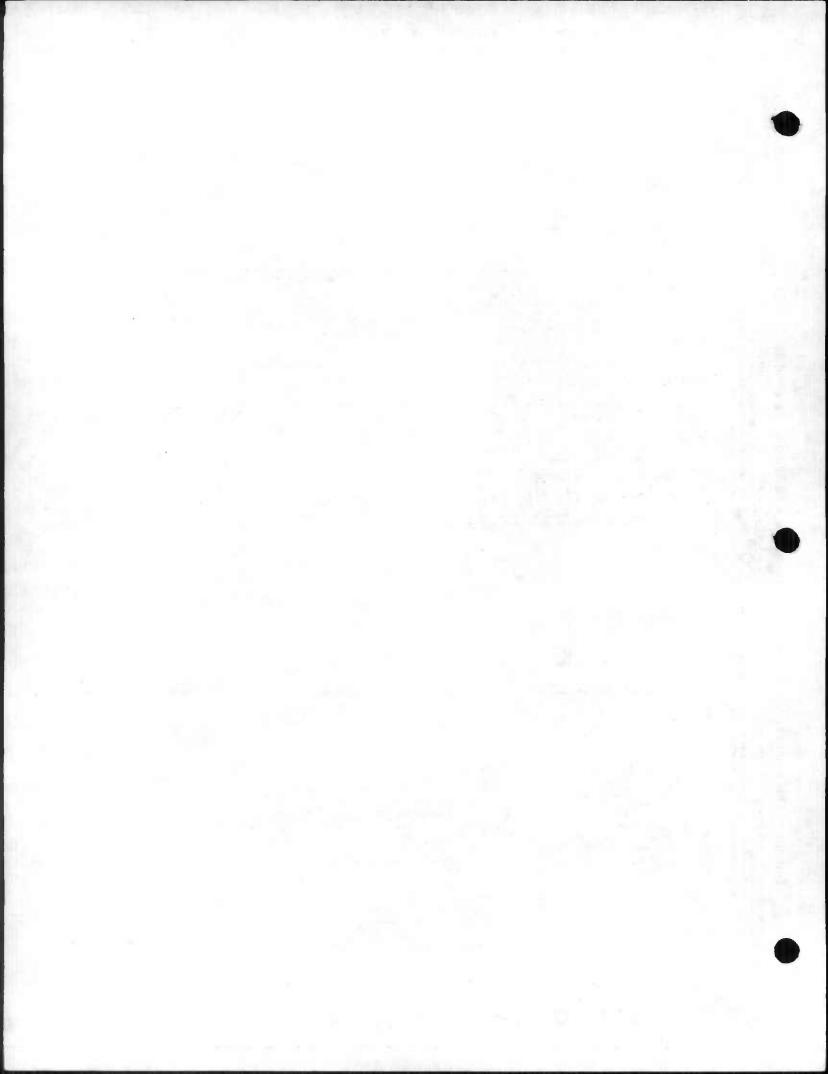
2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated. Medical (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 Mis DO1663 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 906C WASHINGTON D WESTMINSTER MD -0 FIDELO TR 21157 32. Registrer's Signature 31. Dete filed (Month, Day, Year) State **SEP 27** 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	3	State of Maryland		rtment of I tificate of			giene Reg. No.	3	1531			
Physician /Medical	1. Decedent's Name (First, Middle, Last	N.	Ke	114		2. Dete of De Month Septemb.	er 22, l	Yeer qqq	3. Time of Death 09:15 a.m.			
Examiner	4a Facility Name (If not institution, give To NNS Hopkins Hosph 5. Social Security Number 6. Se	tal	act hinth days	If Under 1 Year	4b. City, Town, or Lo	none			(0.1)			
Funeral Director		7. Age (In yrs. Is 21	Yrs.	Months Days	Hours Min.	8. Dete of Bir (Month, Da June 29	9 1978	Count Md	ace (State or Foreign lry)			
Maryland H ahow	Md 10b. County Carroll		Town or Loc ykesvi					10	od. Inside City Limits 1 ☐ Yas 2X No			
h with the Ma 3a or 28a-f a at be notified		đ		10f. Zip Code 21784			10g. Citizen of V USA	Vhet Count	ry?			
1215-0020 within 72 hours after death with the Manyland ans. than "natural, or hams 28a or 28a-l ahow he Madoel Esserines must be notified at a more and a notified at a more and a notified at a more and a notified at a more and a notified at a more and a notified at a more and a notified at a more and a notified at a more and a notified at a more and a notified at	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever In U,S Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Detes:	If	/es Decedent of H Yes, specify Cub	dispenic Origin? (Span, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)	No- 14. Rece - American Indian, Bleck, White, etc. SpecifyWhite					
d 21215-0020 filed within 72 hours at Mylene. ther than "natural", or ent, the Medical Exam ort, the Medical Exam or Completed by F	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedi (Give I life. D stude		pation during most of work d)	ing	16b. Kind of Bu		ustry			
Maryland 2 d 2 should be filled th end Mentel Hygin th end Mentel Hygin th end Mentel Hygin the end Mentel the end Mentel To Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nemo							
1 and 2 sho Health and 1 om 27 le me other traums	Jacquelyn A. Kelly				and Number or Run Rd., Syk				Code)			
Baitimore, Maryland 212: permit. Pages 1 and 2 should be filed within popertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than any Injury or other traumatic event, the Health. To Be Comp		Removel from State Tak	metery, crem	ition (Name of atory or other pla Memoria	al 9-	Dete -25-99	20c. Location - Sykesvil					
Baltimor permit. Pages Deperment of I important: If its eny injury or of ance.	1 (XBurial 2 Cremation 3 Removel from Stete Lake View Memorial 9-25-99 Sykesville, Md 21. Signature of Funeral Service Upensee P.O. Box 195 Sykesville, Md 21784											
Physician /Medical	23a. Part1. Enter the disease, or compishock, or heart teilure. List only of								Approximete Interval Between Onset end Death			
Examiner	disease or condition resulting in death)	Due to (or CYSTIC FI	as a consequ	uence of):				1	- Lyears.			
68760, difficate be executed to physician end as the burlet-transit Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of):											
P.O. BOX 68 at the death certifical by the attending pleached for use as the Physician/Mec	Part II. Other significant conditions con	d	iting in the un	dedving cause on	ven in Pert I	23h Did	Id tobacco use contribute to the cause of death?					
U = 5 5		The second section of the second		outying outstory.		10	- V		ebly 4 ☐ Unknown			
DCOFC NW requir s been a 2 should			-				an eutopsy med?	eva	re autopsy findings illable prior to npletion of causa leath?			
	25. Was case referred to medical examiner?				26. Place of Deat	1 🗆 t	/-	1 🗆	Yes 2 No			
는 분들 H	1 Yes 2 No	1	R/Outpatient	3L DOA	-		dence 6 Oth)			
DIVISION O DIVISION O But or Attending Ph a stor death. el Director: After th led in by the funeral Certification:	1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Plece of Injury - At hon building, etc. (Specify)	Injury		Yes 2 □ No		Street and Numb		Route Number,			
DIVIS To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th Medical Certific	(Check only 2 Medical Exami-	sician: To the best of my know her: On tha besis of examination	ledge, deeth	occurred at the tile	me, date and place,	end due to lhe	cause(s) and me	nner as sta	ated. the cause(s)			
To the To the Complete	29b. Signature and title of certifier	- resident p		29c. Licens	se number		29d. Date signed Septemb	d (Month, L	Day, Year)			
	30. Name and address of person who co	Tower 10, To	23a) (Type, F) hn { H	rint) oplains H	ospital, B	altimm	e, Mary	land	21287			
State Registrar	31. Date filed (Month, Day, Year) SEP 2 4 1999	32. Registrer's Signetu	G.	Spark								

DHMH 16 Rev 6/95



Ple

Pleas	e Type or Print State of Ma	yland / De	partment o	f Health and	_	JP1, 118	-	1632
		C	ertificate d	of Death		Reg. No.		
Decedent's Neme (First, Middle, ALICE WI	Lasi) LLIS KEE	FE			2. Dete of De Month Septen	Dey	Yeer 1999	3. Time of Deeth 8:00 am
4e Facility Neme (If not institution,				4b. City, Town, or				0.00 am
4941 Chavez Lan	e			Chesape	ake Beac	h Calve	ert	
5. Sociel Security Number 577 48 6892 Usual Residence of Decedent	5. Sax 7. Age 1	(In yrs. lest birthda 9 Yrs	Months De			ey, Year)		lece (Stete or Foreign try) Sh., DC
10e. Stata 10b. County	lvert	10c. City, Town or Chesap	Location eake Bea	ch			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
10e. Street and Number	1		10f. Zip Coo	de		10g. Citizen of	Whet Coun	itry?
4941 Chavez Lar	ne		207	32		USA	A	
11. Marital Status	12. Wes Decedent Ev	ar in U,S. 1	3. Wes Decedent	of Hispanic Origin? (Specify Yes or N	o- 14. Rad	ce - Amaric	
1 Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	Armed Forces? d 1 \(\text{Yas} 2 \(\text{ZNo} \) If Yes, Give Year or Datas:		If Yes, specify 0 1 ☐ Yes 2 🕱	Cuban, Maxican, Puè No <i>Specify:</i>	rto Rican, etc.)		ck, White, y: whi	
15. Decedent's	Education	/G	cedent's Usuel Ocive kind of work do	one during most of w	orking	16b. Kind of B	usiness/Inc	dustry
Elamantary/Secondary (0-12)	Coitage (1-4or 5+	life	e. DO NOT use re	etired)				
17. Fethar's Neme (First, Middle, Li	- T	11	omemaker		ame (First, Middle	OWN I		
	ilton Wil	lis		Alic			vens	
19e. Informent's Neme/Raletlonshi			ailing Addrage /St	reet and Number or F				
					10/0/1/08/0/170/1/1	oon, only or roun.	, 0.0.0, 2.0	0000)
Robert F. Keefe 20e. Method of Disposition 1 Buriel 2 X Cremation 3	B □Removel from State	20b. Plece of Discemetery, of	e as 10 sposition (Nema of crametory or other litan Crametory or other	f place)	9-25-9	20c. Location 9 Alexano		
4 Donetion 5 Other (Spe 21 Signature of Furtieral Service Li		raceropo	22. Neme end Ad	-		ATEXAIL	шта,	VA
M. Theh	1 Phon			Funeral H	ome, Ow	ings, MI	20	736
Immediate Cause (Finel disease or condition rasulting in death)	· Lun	can	cer	dying, such es cardi	ac or respiretory	errest,	6 1 1 1	Approximete Intervel Between Onset and Deeth months
Sequantially list conditions, if eny, leading to immediata ceuse. Enter Underlying	b	ue to (or es e con	sequance of):					
Causa (Disaase or Injury that initieled avents resulting in deeth) Lest	c	ue to (or as e cons	sequenca of):					
Pert II. Other significant condition metas tas		not resulting in th	e underlying ceus	e given in Pert I.		tobacco use co		o the cause of death bably 4 Unknow
						s en eutopsy formed?	ev	ara eutopsy findings alleble prior to impletion of cause deeth?
					10	Yes 25No	10	Yes 2KNo
25. Was casa rafarred to medical				26. Plece of D	eath (Check only	ona)	1	
examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient	2 ER/Outpe	tient 3 DOA	Other:	Homa 5 Res		her (Specif	(y)
27. Mannar of Death 1 Available 5 Panding investiga	28a. Date of Injury (Month, Dey	28b. Tim	a of 28c.	Injury at Work? 1 ☐ Yas 2 ☐ No		how Injury occu		
2 Accident Investiga 3 Sulcida 6 Could no datarmin	ot be Ope Place of Injur	y - At home, farm,			28f. Location (Street and Number or Rural Route Number, City or Town, State)			

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Departs. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Experience must be notified at once.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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3 ☐ Sulcide 4 Homicide

Physician/Medical Examiner

the attending physician and thed for use as the burial-trensit signed by

by

Completed

Certification: To Be

edicai

State Registrar

The lew requires that the death certificate be execu completaly filled in by the funeral director, page 2 should be datached for within 24 hours after death.

To the Funeral Director: After this certificata hes been To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

12

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. 29a. Certifiar (Check only one) 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature god title of certifier D16823

20678

30. Nama and address of person who completed ceuse of death (Itam 23a) (Type, Print)

Robert Schlager, Prince Frederick, MD M.D.

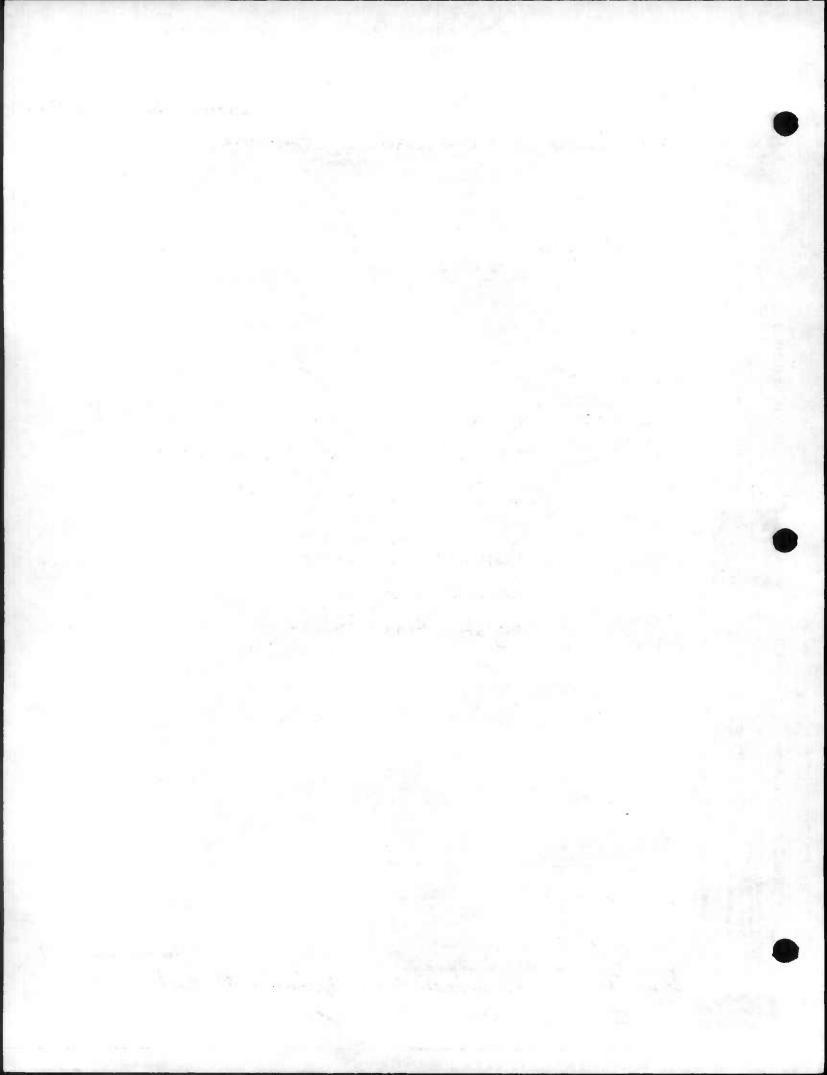
31. Dete filed (Month, Dey, Yeer)
SEP 2 3 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Death		Reg. No.		1000
Physic /Med		1. Decedent's Name (First, Middle, Last) Sames A. Millen	2. Date of De		Year 1999	3. Time of Death
Exam		4a Facility Name (If not institution, give street and number) 4b. City, Town, or L				0. //_
Funera Directo		5. Social Security Number 214-01-3038 6. Sex 17. Age (In yrs. last birthday) 16. Months Days Hours Min.	8. Dete of Bir (Month, Da NOV 12	th iy, Year) 1906	9. Birthpl Count N. Y.	ace (State or Foreign ry)
P ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				Ad 4-14-00-11-0-
Maryle Maryle Maryle Maryle Maryle	ctor	Md Corroll Cyleographic				0d. Inside City Limits 1 Yes 2 □ No
th with th	al Director	10e. Street and Number 7200 Third Ave. B204 21784		10g. Citizen of V USA	/hat Coun	try?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiens. Important: If them 27 is marked other than "natural", or hame 23s or 28s-1 show any highty or other treumatic event, the Madesi Eventher must be notified as	by Funeral	If Yes, Give 1 Yes 2X No Specify:	pecify Yes or No o Rican, etc.)		- America k, White, c -White	etc.
21215-0020 d within 72 hours aft giens. In than "natural", or the section for pre-	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work tife. DO NOT use retired)		16b. Kind of Bu		i ka
d 212 flied with Hygiens. ort, the	Com	aeronautical engineer		Martin M		tta
Maryland d 2 should be flie h end Mental Hy T la merked oths treumetic event	To Be	17. Father's Name (First, Middle, Last) James A. Millen 18. Mother's Nam Ida Lydi		, Maiden Sumem	Θ)	
ond 2 should end 2 should seith end Men n 27 is marke er treumstic		19a. Informant's Name/Relationship (Type, Print) Margueritte C. Millen (spouse) 19b. Mailing Address (Street and Number or Rui 7200 Third Ave. B204,				
Pages 1 end hant of Heelth unt: If Hem 27 Jay or other tr		20a. Method of Disposition 1	Date 9-23-99	20c. Location - Sykesvi		
Baltimol permit. Pages Department of Important: If it eny injury or or		21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Hai P.O. Box 195 Sykesv	ight Fun ville Mo	eral Hon 21784	ne & (Chapel
Physician /Medical Examines		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feiture. List only one cause each line. Immediate Cause (Finel disease or condition resulting in death) a. Respiration of the mode of dying, such as cardiac shock, or heart feiture. List only one cause each line.	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death
BOX 58760, nath certificate be associted attending physicien end if or use as the burlei-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Congestive Factories Due to (or es a consequence of): d.				
death certification of for use e	Iclar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	225 Did	tobacco use cor	tribute to	the cause of death?
P.O.	/ Physician/M	Diasetes, Hypothyroidism, CAD		Yas 2 No	3 Prot	. /
requir	Completed by		24a. Was perio	an autopsy ormed?	ava	ore autopsy findings vilable prior to npletion of cause death?
Y 6	mo		10	Yas 20 No	10	Yes 2□ No
VITAL I	Be	25. Wes case referred to medical examiner?	th (Check only	one)	l	
- S 00	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H		dence 6 Oth)
Atta fund	Certification:	28a. Date of Injury (Month, Day Year) 28b. Time of Dest. Time of Injury (Month, Day Year) 28c. Injury at Work? 1 Yes 2 No 28c. Natural Source 4 Homicide Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		how injury occur Street and Numb wn, State)		l Route Number,
DIVISION To the Hospital or Attance Within 24 hours after deatt To the Funeral Director: completely filled in by the	l Cer	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,			nner as st	aled
the Hou In 24 h the Fur Ipletely	ledical	(Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occur and manner stated.	rred at the time,	date and place,	and dua lo	the cause(s)
To Too	Σ	29b. Signature and title of certifies 29c. License number 000 5 1 8 5	7	29d. Date signer September	2 2	2 1999
		30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Adam Bersch 22 S. Green Street Baltimore	e Man	lovel a	212	0/
St Regis	tate trar	31. Date filed (Month, Day, Year) SEP 2 4 1999 32. Registrar's Signature G. Sports	7			

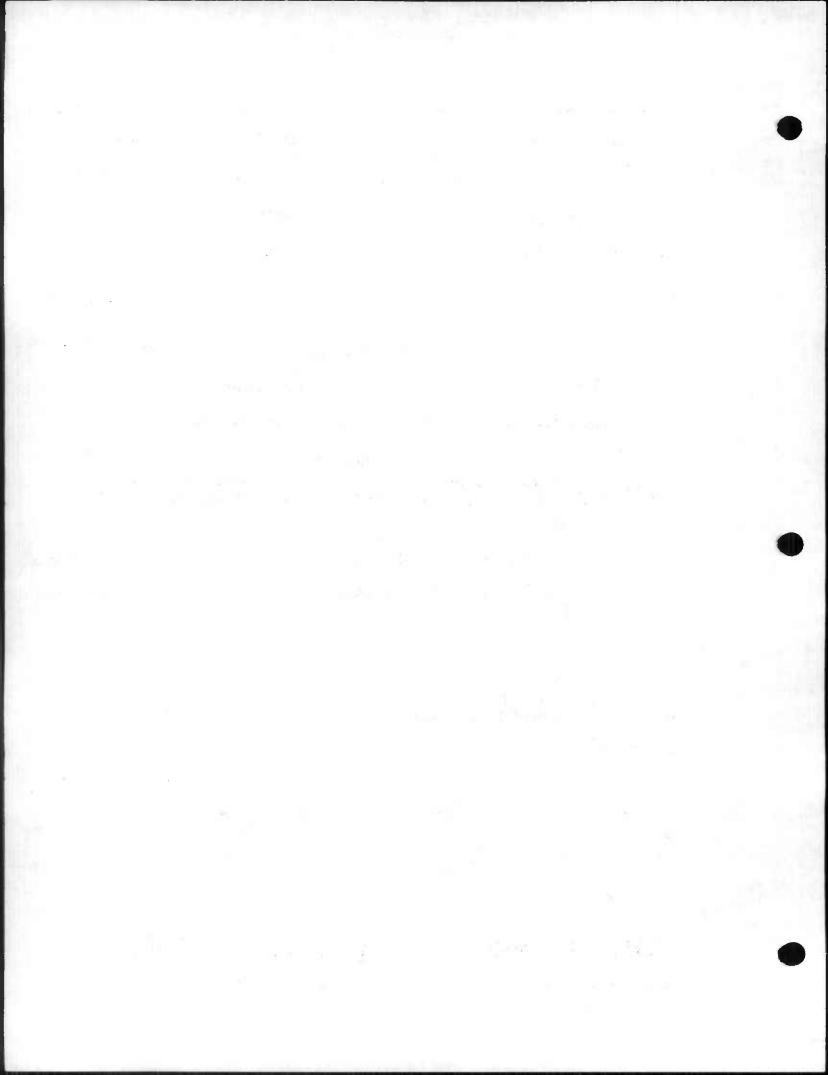
DHMH 16 Rev 6/95



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			Sta	te of Ma	ryland / I	Departmer Certificat			d Mental Hy	/giene	3	1634
	Dhusia		1. Decedent's Name (First, Middle, Last)						2. Date of D		Year	3. Time of Death
	Physic /Medi		Machree Elizal		ott				Sept		999	6:30 am
	Exami	ner	4a. Facility Name (If not institution, give street a 30 Manchester Avenue				4	b. City, Town, Westmi	or Location of Dea		y of Deeth	
Н	Francis		5. Social Security Number 6. Sex		(In yrs. lest bii	nthday) If Under	r 1 Year	If Under 24	Hrs. 8 Dete of B	irth	Carro.	L L place (Stete or Foreign
	Funeral Director		220-16-2765 1□ M 2		85	Yrs. Months	Days	Hours I	Nov 9	ey, Year)	Cou	yland
	D >		Usual Residence of Decadent 10a. State 10b. County		100 Oit T-							
	Aaryla I shor	5	Maryland Baltimore		10c. City, Tow	n or Location	I	Manches	ster			10d. Inside City Limits 1 ☐ Yes ※☐ No
	28a-	Director	10e. Street and Number			10f. Zic	Code			10a. Citizen of	What Cou	
	h with	al Di	19601 Gunpowder Road					21]	L02	-		,
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show pilcal Evantive must be notified at	Funeral	11. Marital Status 12. We	s Decedent Ev	ver In U,S.	13. Was Deca	dent of Hi	spenic Origin n. Mexican, P	? (Specify Yes or N uerto Rican, etc.)	o- 14. Ra		
20	s afte	by Fu	1 Never Married 2 Married 1	Yes 2 No es, Give ar or Dates:		1□ Yes						
9	72 hour	ed b	15. Decadent's Education		16a	. Decedent's Usu	al Occupa	ation		16b. Kind of I	Business/fr	ndustry
215	within 72 ho jene. r than "natur rns Medical	Completed	(Specify only highest grade comp	<i>leted)</i> lege (1-4or 5+		(Give kind of wo life. DO NOT u	rk done d se retired	lu <i>ring</i> m <i>o</i> st of)	working			
21	al Hygien other th	Con	12		= 4	Assemb.	ly Li					Decker
Maryland 21215-0020	ad be fi	Be c	17. Fether's Name (First, Middle, Last) George Miller						Name (First, Middle ella Kelle		me)	
ary	2 should be 1 end Mental I is marked of sumatic eve	To	19a. Informant's Name/Relationship (Type, Pri	nt)	196	. Mailing Address	(Street e				n. Stete. Zi	p Code)
Ž.	Health er Health er em 27 is other trau		Carrie M. Nott, daugh	ter	1							,
Baltimore,	permit. Peges 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remova	I from State	20b. Place o cemete	f Disposition (Ner ry, crematory or o	ne of other plec	9)	Date			
tim	a je re		4 ☐ Donation 5 ☐ Other (Specify)	THOM OLULO	Carı	coll Cre			9/24			, MD
Bal	permit. Pe Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee	19	10.	22. Name ar						0.57.4
			23a. Part1. Enter the disease, or complications	that caused the	ne death Do						4D 21	
A. I	Physician /Medical Examiner	ē	shock, or heart failure. List only one caus Immediate Cause (Finel disease or condition resulting in death) e.	lyxan	dial	consequence of):	nch					Interval Between Onset and Death
9 x 0	sain certificate be executed ettending physician and for use as the bunal-transit	in/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last			consequence of):	٥					years
O. B	the death y the etter sched for u	Physician/M	Part II. Other significant conditions contributing	g to death but	not resulting in	n the underlying o	ause give	en In Part I.	23b. Dic	tobacco use c	ontribute t	o the cause of death?
s, P.C	es thet the death igned by the etter be detached for u	by Phy	High Cholester	of le	wels)			10	Specify: White 16b. Kind of Business/Industry Black & Decker 16e, Meiden Surneme) er ber, City or Town, Stete, Zip Code) er, MD 21157 20c. Location - City or Town, State Hampstead, MD Funeral Home stead, MD 21074 errest, Approximate Interval Between Onset and Death Seconds 4 Unknown 17es an autopsy formed? 24b. Were autopsy findings evallable prior to completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No		
Record	sw requir	Completed	Dementia								6/	vailable prior to empletion of cause
									1 🗆	Yes 2 No	1	Yes 25 No
Vital	rnystetan: in this certificete rel director, pag	o Be	25. Wes case referred to medical examiner? 1 Yes 2 No Hospitel	1 ☐ Inpatient	ο Π Ε ΒΙΟ	utpetient 3 DC	Othe	A.F.	Death (Check only			
Division of	to the respiral or Attending Frigstrant: within Earhours affected the Tarbertal Director; After this certific completely filled in by the funeral director,	-	The second secon	Dete of Injury (Month, Day)			28c. Injury Work	4 LI NUISII				ny)
Divis	al or Attending s after death. If Director: After ed in by the fune	Certification:	3 Sulcide 6 Could not be determined 28e.	Place of Injury building, etc.	/ - At home, fe (Specify)	rm, street, factory	y, office				ber or Rur	ei Route Number,
1	within 24 hours after To the Funeral Dir. completely filled in	edicai	(Check only 2 Medical Examiner: On	To the best of the basis of earth manner state	xamination an	dor investigation	at the tim , in my op	e, date end pi inion, death o	iace, end due to the occurred et the time	ceuse(s) end m	enner es : , and due t	steted. o the ceuse(s)
F	within 2 To the	Σ	29b. Signature and title of cartinu	~			. License	1.0		29d. Date sign	ed (Month,	Dey, Year)
			PROPERTY	ND			003	6112		9/22/	44	
			30. Name and address of person who complete Dr. A. Rocha, 4231 No.				nate:	TM be	21074			
	Sta	te	31. Date filed (Month, Dey, Yeer) SEP 2 7 1999	32. Registrar's					Z1U/4			
	Registr	ar	SEP 2 7 1999	popular	- /	9. Son	21	,				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕥 🗅 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month **Physician** 1999 10: 40 pm HARRY MILTON NICHOLSON /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Comm Wastminster Carrell If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Under 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days DEDM 20 F Months 78 Director 213-16-2279 July 18, 1921 Virginia Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland and chealth and Montal Hygiene.
Int: If them 27 is marked other than "natural", or items 23a or 28a-1 ahow may or other thaumatic event, in the death in the master noticed at my or other thaumatic event, in the death in the more and in the death in the d 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4400 Middleburg Rd.

Marital Status

12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 □ No If Yes, Give Yes, Funeral 21791 Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 2 If Yes, Give Year or Dates: White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Midwest Emery Elementary/Secondery (0-12) College (1-4or 5+) Owner/Operator Trucking Company 6 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Elizabeth P. Baker Wade E. Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) <u> Doris H. Nicholson (Wife)</u> 4400 Middleburg Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or otice. 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 9-28 Finksburg, MD 21 Separature of Funeral Service Licenses 22, Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster. 21157 23a. Parl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** BFT LUNG CANCER /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner The law requires that the death certificata be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760, Physician/Medical phys. Due to (or as a consequence of) 88 Part It. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 0 1 Yes 2 No 3 Probably 4 Unknown p 8 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed C 2 8 1 🗆 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 10 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 12 Natural
2 Accident Division 5 Pending investigation n 24 hours after death.

No Funeral Director: After pletely filled in by the fun 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier X A Medica (Check only one) within 2 29b. Signature and title of carrifler 29c. License number 29d. Date signed (Month, Day, Year) D29264 rows 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) N. RAJORCA. 21) WASHIMOTON WTS, WESTMINSTER MD 21157

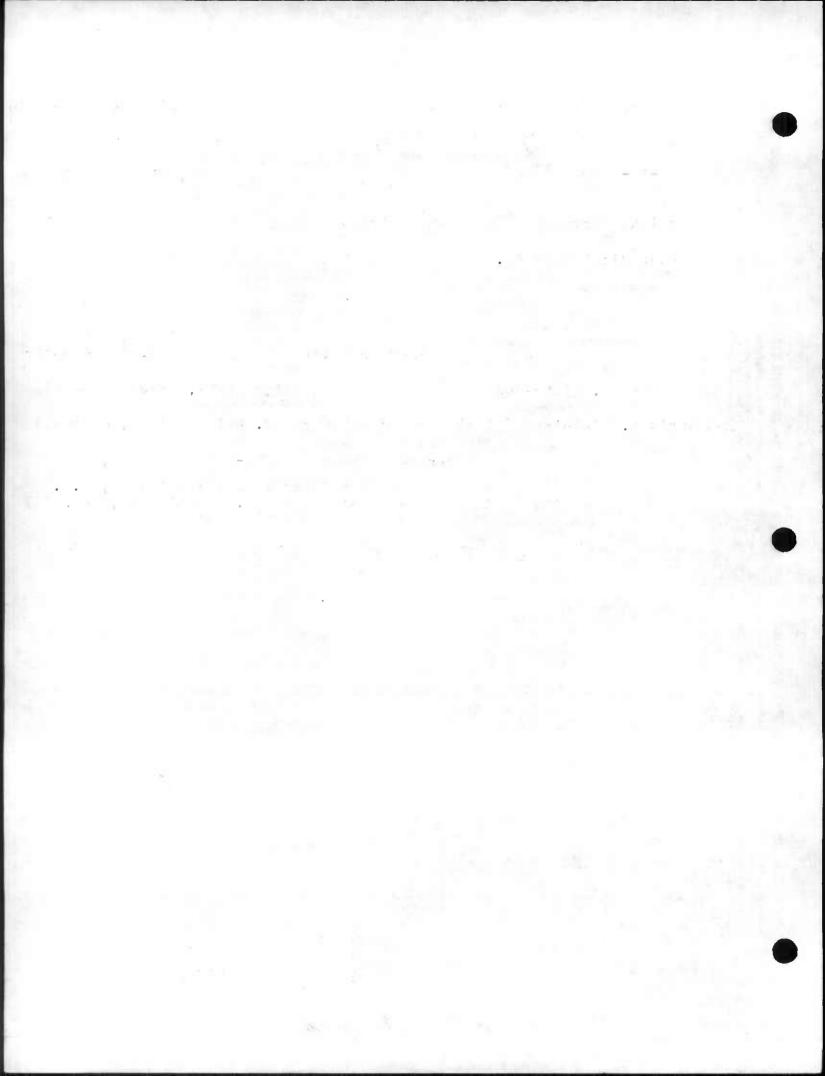
Registrar

State

31. Dete tiled (Month, Day, Year)

ORIGINAL

32. Registrar's Signature



Ammend #6 Female Cal.Co. Health Dept. KDS 9/30/99

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Certificate of Death	H	eg. No.	
Physician	1. Decedent's Name (First, Middle, Last) Lena A. Parratore	2. Date of Deal Sept.	25°, 19	3. Time of Deeth 12:30 P.
/Medical Examiner	4a Facility Neme (If not institution, give street and number) 470 West Dares Beach Road Apt. 409 Prince F	Location of Death	4c. County of	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 342 05 1709 Wish 20 F 78 Yrs.		Year/920	Birthplace (State or Foreign If Thousand
r 28a-f show Incitrad at irector	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Prince Frederick 10b. County 10c. City, Town or Location Prince Frederick 10c. City, To			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
23e or 28e unt be noti	10e. Street and Number 470 West Dares Beach Road Apt 409 20678	1	Og. Citizen of Wh	states
or items rainer m	11, Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Specify Cuban, Mexican, Puer of Dates: 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:	Specify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. White
Medical	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use rating)	orking	16b. Kind of Busi	
event, the Be Com	8th homemaker	me (First, Middle, I	own hoi	
	Anthony LaCoco Joseph	ine Rin	nella	
OL	19e. Informant's Name/Reletionship (Type, Print) Angie Rivera-daughter 5848 Long Beach Dr			
any injury or other once.	20a. Method of Disposition 1	1 1999 tery		ity or Town, State nham Marylan
eny injury once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ra 4405 Broomes Is			
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.			Approximate Intervel Between
cian licai iner	Immediate Ceuse (Final disease or condition resulting in death) a. Corumany arthy 186 odd. Due to (or as a consequence d):			Onset and Death
burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):			
inding physicial use as the bur in/Medical	Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of):			
be datached for u	Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the cause of death?
should be d		24e. Was a perfor		24b. Were autopsy findings available prior to completion of cause of death?
Comp	25. Wes case referred to medical 26. Place of De	1 ☐ Yo	es 2 No	1 Yes 2 No
To Be	examiner?	Home 5 Resid		(Specify)
nuera On:	27. Menner of Deeth 1 CNatural 5 Pending (Month, Day Year) 2 Accident Investigation 3 Suicide 6 Could not be		ow injury occurred	
ed in by	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town	treet and Number n, State)	r or Rural Route Number,
To the Funeral Director: A completaly filled in by the fi	29a. Certifler (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place to the control of the contr	a, and due to the c urred at the time, d	ause(s) and meni lete end place, en	ner as stated. ad due to the cause(s)
W We	29b. Signature and title of certifier P.M. R. D. 46314	1		(Month, Day, Year) ber 27, 1999
	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Paul V. Pomilla, M.D. 110 Hospital Rd. Suite	310 Pr	inceFr	20678 ederick MD
State Registrar	31. Date filed (Month, Day, Year) SEP 2 8 1999 32. Registrate Signature 4. Spaces			

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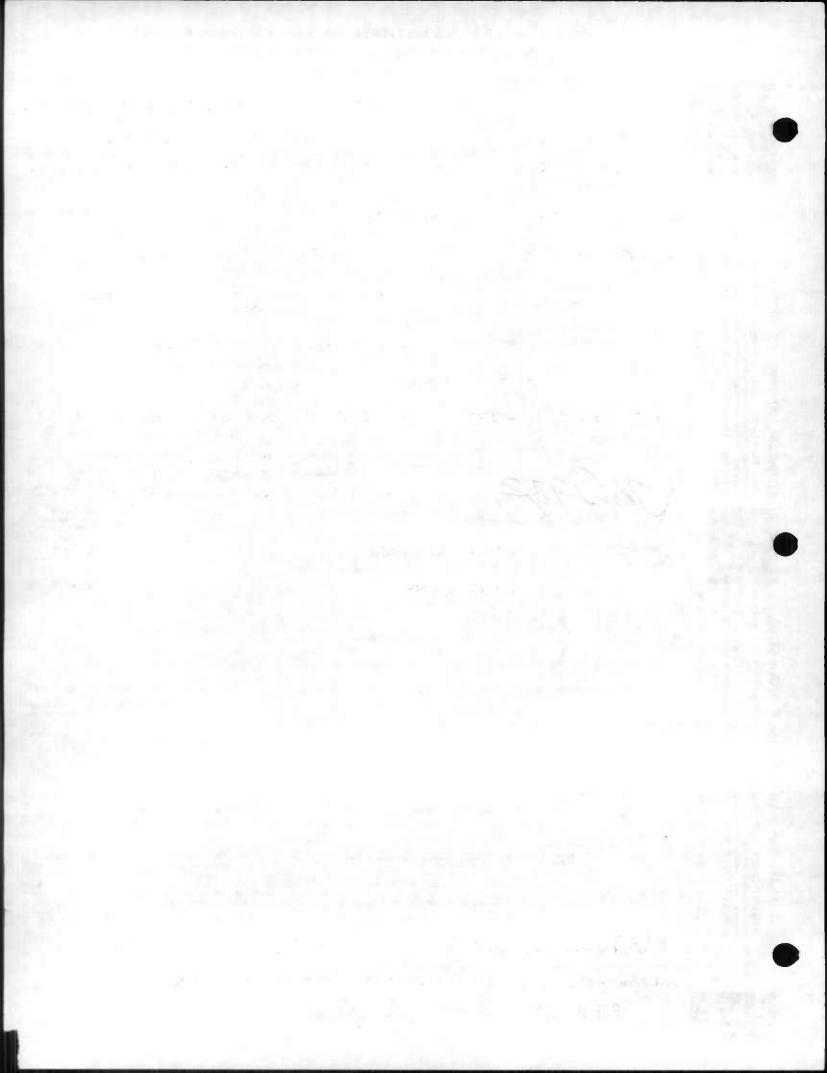
State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate d	of De	eath			Reg. No.			
Physician /Medical	1. Decedent's Name	(First, Middle, La		ILIO A	ALBERT	ROUSS			S	2. Date of De Month EPT.	22, 1		5:30	of Death
Examiner	4a Facility Neme (If 172 OTHE	mber)	V			4b. City, Town, or Location of WESTMINSTE			TER CARROLL					
Funeral Director	5. Social Security Nu 076-26-6	5191	Sex 17∑1 M 2□ F		vrs. last birthday, 65 Yrs.	Months De		Under 24 Hours	Hrs. Min.	8. Dete of Bir (Month, Da 3 / 22 /	th 1934	9. Birth Cou PUE	place (Stete intry) RTO F	e or Foreig
death with the Marylend rms 23s or 28s-f show Linual be notified at neral Director	Usuel Residence of I	10b. County CARROL	L	10c.	City, Town or L								10d. Inside	City Limit
rec	10e. Street and Num	ber				10f. Zip Cod	de				10g. Citizen o	Whet Cou	intry?	
3a o	172 OTHE	ELLO CO	URT			2	115	7			USA			
urs efter	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Wes Dec Armed Fo 1 Tes tt Yes, Gi Yeer or D	orces? 211 No ve	n U,S. 13.	Was Decedent of Hispenic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☑ Yes 2 ☐ No Specify: PUER				cify Yes or No Ricen, etc.) JERTO	Yes or No- n, etc.) 14. Raca - Am Black, Wh RTO Specify: WI			
n 72 hours natural;		15. Decadent's E	ducation		16e. Dece	dent's Usuel Oc	cupetio	n			16b. Kind of	Business/I	ndustry	
ed within 72 houygiene. The Medical It, the Medical Completed	Etementery/Second 1 2	y only highest gradery (0-12)		Coilege (1-4or 5+)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of work life. DO NOT use retired) BAKER				FOOD				
should be filed and Mental Hygic marked other imatic event, II	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Last)							, Maiden Sum CAMA	_ '					
and 2 should auth end Men 27 le marke er traumetic	19e. Intorment's Ner ESTHER R			IFE		ng Address <i>(St</i> OTHELL								157
Pages 1 and nert of Health outs If Ilem 27 iry or other ti		Cremetion 3		20b. Place of Disp cemetery, cre			place)	м.	9/2	Date 5/99	20c. Location			
pemil. Pages 1 a important: If the any injury or othe anse.	4 Donetion 5 Other (Specify) MEADOW BRANCH CEM. 9/25/99 WESTMINS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL 254 E. MAIN ST., WESTMINSTER,										RAL	HOME		
Physician /Medical Examiner pur up up up up up up up up up up up up up	23a. Next . Enter the shock, or heart tramediate Ceuse (F diseese or condition resulting in deeth)	failure. List only	a. BR	Pue to	METATTA to (or es e conse	2124	dying, s	such es ca	rdiec or	respiratory e	mest,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Approxim tnterval E Onset en	NOS
certificate be nding physicia use es the bur n/Medical	Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): d													
that the death led by the attended for un	Pert II. Other signific						old tobacco use contribute to the cause of deat							
requires the been signe should be called by							24e. Wes			Were eutops eveitable prio completion of t death?	or to			
The law sta has page 2										10	Yes 2 No		□Yes 2	2□ No
ysician: The list certificate he director, page	25. Wes case referre	ed to medical					2	6. Place of	f Deeth	(Check only	one)			
Physician: this certific ral director.	examiner?	lo	Hospital:	Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA	Other:					Other (Spec	cifv)	
After fune	27. Menner of Deeth 1 Neturel 2 Accident	5 Pending investigation	28e. Dete (Mon		ent 3 DOA 4 Nursing Hom			ome 5 PResidenca 6 □Other (Specify) 28d. Describe how injury occurred						
To the Hospital or Attending P within 24 hours efter deeth. To the Funeral Director: Affert completely filled in by the funeral Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	- At home, term, street, factory, office 28f. Loc Specify) 28f. Loc						ocation (Street and Number or Rurel Route Number, city or Town, State)					
To the Hospital within 24 hours To the Funeral I completely filled Medical C		Certifying Pt	miner: On the b								date end plac	a, end due	to the caus	
With To the common M	29b. Signature and ti	itle of certitier	- MC				onse n	umber 3335			29d. Date sig	3/99	h, Dey, Yeer)
	30. Name and address				Item 23e) (Type	Print)	BACI	nman	e,r	ND 2				
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G. Sparks

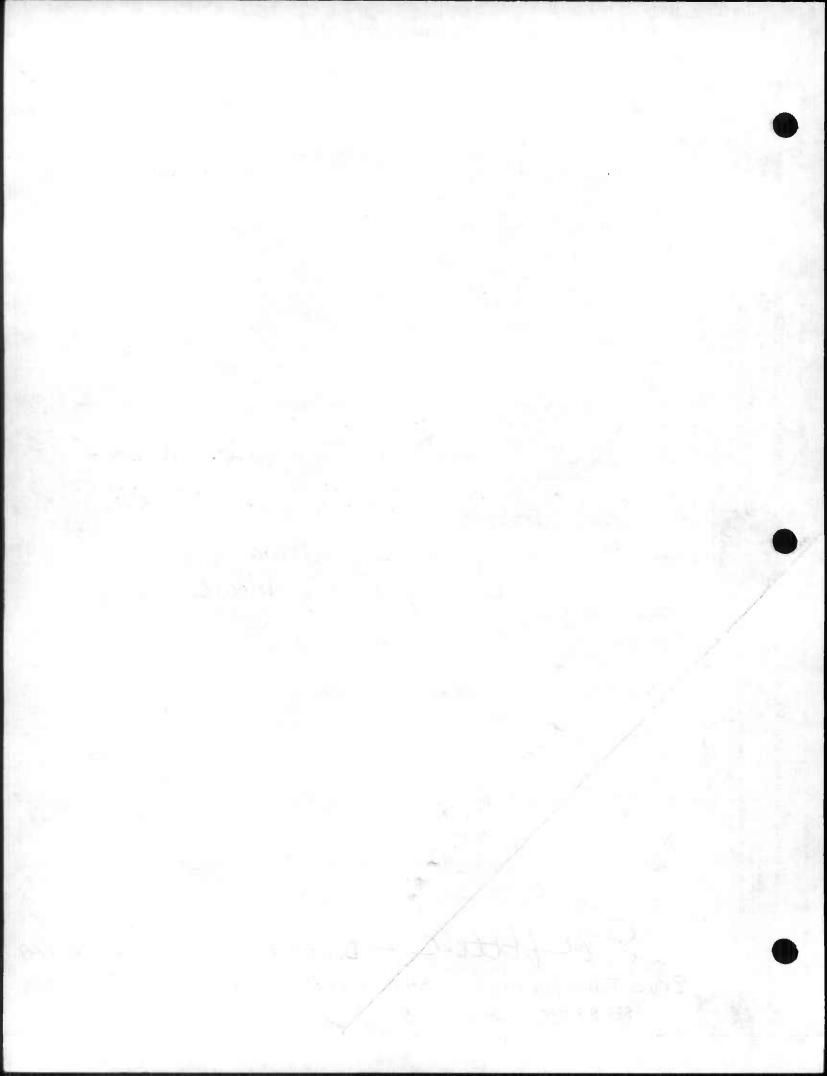
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		State of Maryland / Department of Health an Certificate of Death	id Mental Hy	ygiene 🤰 👙	31930							
	hysician /Medical	1. Decedent's Name (First, Middle, Last) LOUISE Staley	2. Dete of D Month SEDEV	eath	3. Time of Death Year 1049 10: 26AM							
Fu	Examiner	Morthwest Hospital Center Range S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year H Under 24	Hrs. 8. Dete of B (Month, D Oct 31	oth 4c. County Ba irth Day, Year)								
Manyland	4 ehow	Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Carroll Sykesville			10d. Inside City Limits 1 XYes 2 No							
th with the	or hame 23e or 28e-f show imper must be notified at 7 Funeral Director	10e. Street and Number 10f. Zip Code 21784		10g. Citizen of What Country? USA								
5-0020 72 hours after death with the Maryland	9	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried 3 Widowed 4 XDivorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 XNo If Yes, specify Cuban, Mexican, F I Yes 2 XNo Specify:	i? (Specify Yes or N Puerto Rican, etc.)	Bleck	- American Indian, k, White, etc. - White							
within pne.	me in meture in the dead	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15a. Decedent's Usuel Occupation (Give kind of work done during most of life. DO NOT use retired) Auditing Clerk	f working	16b. Kind of Bu	1,5							
faryland 2 2 should be filed and Mental Hygid	8 .	17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First, Middl rgaret (Ur.	le, Maiden Sumem								
	if flem 27 ie me or other traums	19a. Informant's Name/Relationship (Type, Print) Mrs. Amy Orme (Cousin-in-law) 19b. Meiting Address (Street end Number of 9699 Foy Road Dento 20a. Method of Disposition (Name of 1969)										
Baltimore, permit. Pages 1 e Department of Has	mportant: If Ite any injury or o once	1 Spurial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) 21. Signature of Eyneral Service Licensee 22. Name and Address of Facility	9/29/99	Baltim	City or Town, Stete Ore, MD							
8 E &	eny e	Haight Funeral H Sykesville, MD 2 23a. Pert 1. Enter the disease, or complications ther caused the death. Do not enter the mode of dying, such es ca shock, or heart failure. List only one cause on each line.	21784 (410))-795-1	400 Approximete							
/Me Exar	sician edical miner	Immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if arry, leading to immediate			Interval Between Onset and Death							
	physicis the bus adical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of):										
Box deeth cent	aby the attending stached for use a Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. DI	23b. Did tobacco use contribute to the cause of								
P.O.			10	1 Yes 2 No 3 Probably 4 U								
BCOF WE	2 shoul		24a. We per	24a. Wes en autopsy performed? 24b. Were autop available prompletion of death?								
E &	director, page	25. Wes case referred to medical 26 Place of	1 Deeth (Check only	Yes 2 No	1 Yes 2 No							
- 5	To B	examiner? 1 Yes 2 No Hospitat: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursi	ing Home 5 Re		ar (Specify)							
L Bull	To the Functal Director: After this completely filled in by the funeral Medical Certification; 1	27. Manner of Death Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	281. Location	e how injury occurr (Street and Numbown, State)	er or Rural Route Number,							
the Mospital	pietaly fille	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner steted.	place, end due to the occurred at the time	e cause(s) and ma e, date and plece, a	nner as stated. and due to the cause(s)							
Tot	woo woo	29b. Signature and title of ourtifler 29c. License number D0052	760	Septem	Month, Day, Year) When 26,1999							
	State	30. Name and address of person who coffipleted cause of death (Item 23a) (Type, Print) EVICA TOBIN MULDIOW 5401 OLD COUV 31. Date filed (Month, Day, Year) 32. Registrar's Signeture	+ Road	Rando	Illstown, MD							
R	legistrar	SEP 2 8 1999 B. Souls										

DHMH 16 Rev 6/95

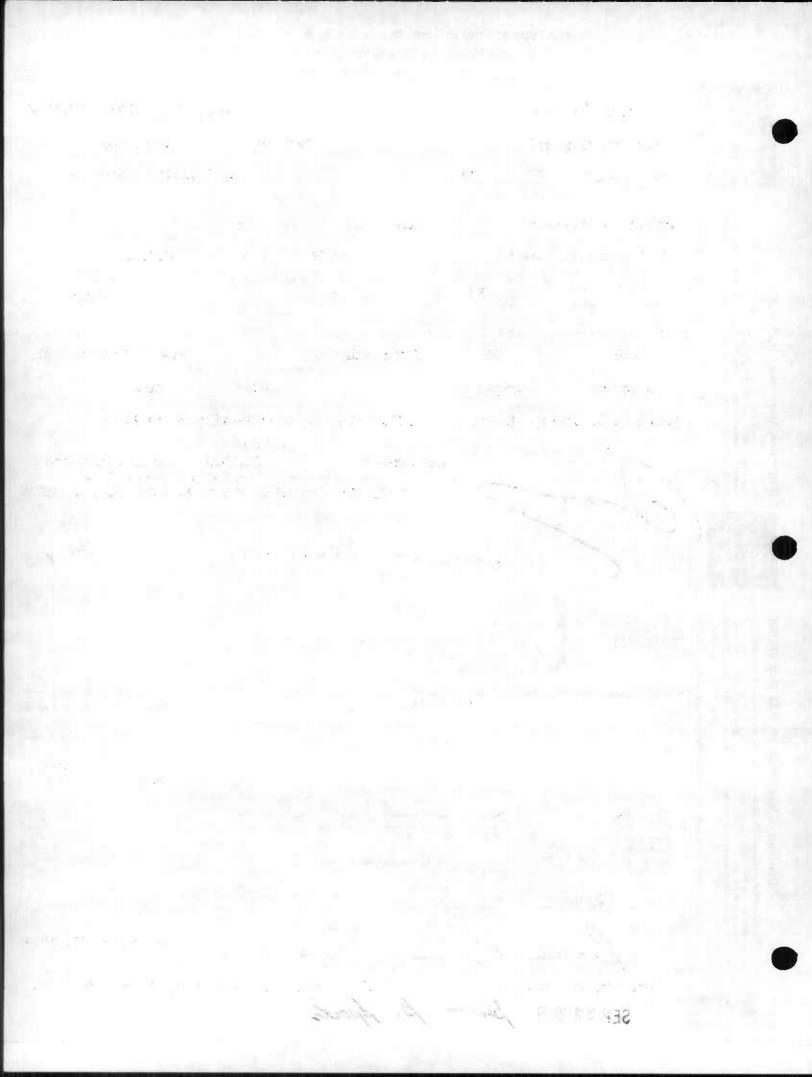


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State of Maryland / Department of Health and Mental Hygiene 3 1639

			4000	- 43							Reg. No.		9 T/ D
Physicia		Decedent's Name (First, Middla, Last)								2. Date of I Month	Death Day	Year	3. Time of Death
/Medic	al _	Jame	s Spri							Sept.		1999	10:45PM
Examin	er	4a Facility Name (I			nber)				4b. City, Town, o	ath 4c. Co	ounty of Death	h	
			an Hospi				4 1 Hilad	der 1 Year	Bethes			ntgamen	ry
Funeral Director		5. Social Security N 216-44- Usual Residence of	4457	Sex 1 M 2 □ F	7. Age (In yrs 85	Yr	Month		Hours Mi	n (Month.	8,1914		nplace (Stata or Foraig untry) W York
show		10a. State	10b. County		10c. C		or Location						10d. Inside City Limits
T W	X -	Maryland	Montgom	ery		Ke	nsingt				1 40- 071-	-434#0	
8 8	급	10a. Street and Nur		D 3			101. 2	Zip Code	_			of What Cou	unity r
23	ra		nornwood	Road	dest Francis I	10	40 Was Dad	2089		(Canaihi Van as	1	S.A. Race - Amer	rican Indian
91,	by Fur	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married 4 Divorced	12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2XXNo	J,S.		pecify Cub	dispanic Origin? an, Mexican, Pur Specify:	erto Rican, etc.)		Black, White	
leal	Completed	(0=	15. Decedent's E	ducetion		16e. D	ecedent's Us	suai Occup	pation	norkina	16b. Kind	of Business/I	Industry
- 40	ple	Etementery/Seco	cify only highast grada complated) ondery (0-12) College (1-4or		-4or 5+)	(Give kind of work of life. DO NOT use if			d)	Orking			
Hygiene. ott, the M	PO.	12th	1	5+		St	aff Sc	cient:	ist		NASA	overnment	
T to S	Be	17. Father's Name		t)					18. Mother's N	ame (First, Midd	fle, Maiden Su	mama)	
marked o	To	Clare	ence	Sprigg	js –				P	da	Fr	ink	
aalth and Men n 27 is marke er traumatic		19a. Informant's Na Patricia	ame/Relationship t C. Spri		Ēe)	1			and Number or				
until if item ury or oth			position [XCremation 3 [5 Other (Speci		20b. Place of Disposition (Nema of cemetary, cramatory or other place) Lee Crematory 20b. Place of Disposition (Nema of cemetary, cramatory or other place) Lee Crematory 20c. Location - City 20c. Location - City 20c. Location - City 20c. Location - City						nton, I	Maryland	
Departs importa any inja ance		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, 6633 Old Alexandria Ferry Road Clint											
100	1												
hysician	(23a. Part1 Enter to shock, or hea	he disease, or con int failure. List only	nplications that co one cause on ea	sused tha dea ach line.	ith. Do no	t enter the m	1			arrest,		Approximete Interval Between Onset and Deeth
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Medical and state burnel transfer	edical	Immediate Cause	onditions, nmediate orlying Injury		Due to (or as a co	F	PROOF):			arrest,		Approximete Interval Between Onset and Deeth
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4 hours after death. Funeral Director: After this cartificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the buris frame.	edical Certification: To Be Completed by Physician/Medical	Sequentially list coif any, leading to inceuse. Enter Unde Cause (Disease or that Initiated events resulting in death) Part II. Other significations of Death (Disease or that Initiated events resulting in death) 25. Was case referencements of Death (Disease or that Initiated events resulting in death) 27. Manner of Death (Disease or that Initiated events of Death (Disease or that Initiated events of Death (Disease or that Initiated events of Disease or that Initiated events or the Initiated events or the Initiated events or the Initiated events or t	inditions, mediate arriving injury sLast ficant conditions ficant co	b	Due to (Due to	or as a coor as a co	insequence of insequence of insequence of the underlying me of the underlying insequence of the underly	DOA Of 1 28c. Injuictory, offices	ven in Part I. 26. Plece of I her: 4 Nursing ry at rk?] Yes 2 No	23b. D 1 24a. W po 1 24a. W po 28d. Descrit 28f. Locatio City or	as an autopsynformed? Yes 25 If yone) asidence 6 [De how Injury of the cause(s) and the cause and p 29d. Date	No 3 Provided No. 10 Provided	onset and Deeth to the cause of death robably 4 Unknor Were autopsy findings avalleble prior to completion of cause of death? N/A 1 Yes 2 No worldy) ural Route Number, stated. to the cause(s)
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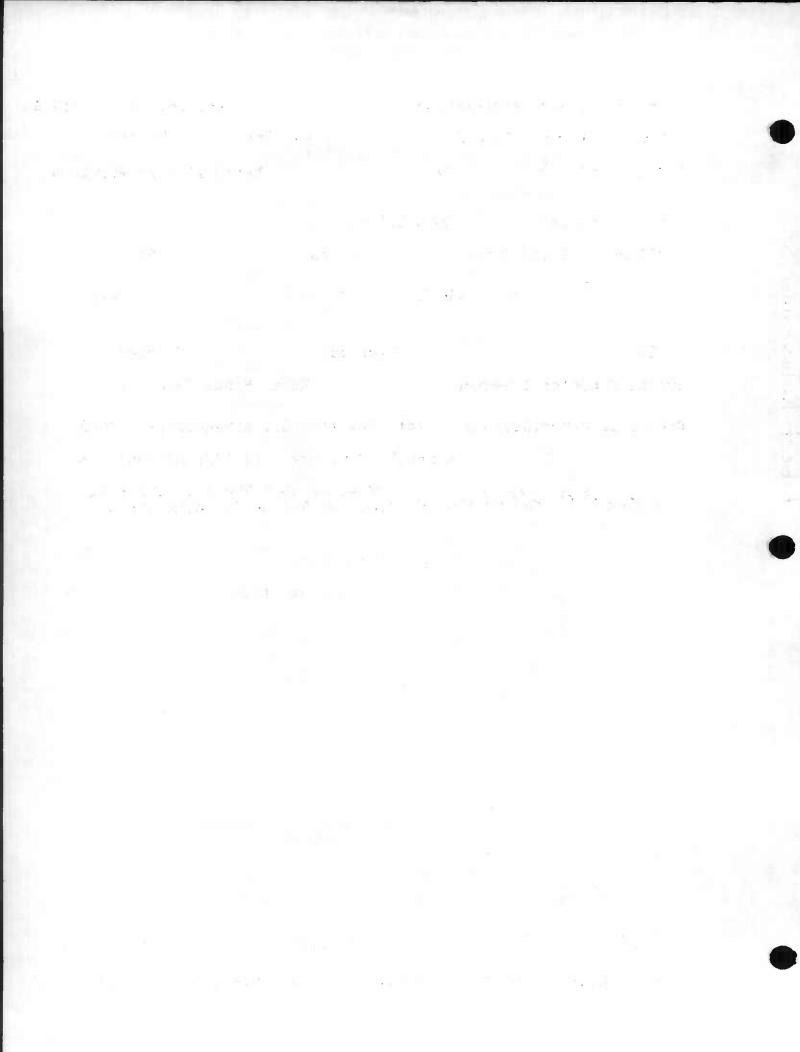


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State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate	of Death	ל	F	Reg. No.	U	040	
	1. Decedent's Name	(First, Middle, Last)					2	2. Date of Dea Month	th Day	Year	3. Time of Death	
Physician	ROBERT RANDOLPH TAVENNER, SR.								Sept. 28, 1		999	7:57AM	
/Medical Examiner	4a Facility Name (If r							own, or Loca	ition of Death	,			
	Civista	a Medica	al Cent	er				Plata			rles		
Funeral	5. Social Security Nur	mber 6. Se	x 7. A	Age (In yrs.	last birthday) If Under 1	Year If Unde	er 24 Hrs. 8	Date of Birth	1,1922	9. Birthp	lace (State or Foreign	
Director	227-18-4	145	3M 2□F	77	Yrs.	MOTITIS	Days Hours	Ma:	rch 2	1,1922	Vir	ginia	
2	Usual Residence of D			1.0.05									
lerylen ed all		10b. County			ty, Town or L						1	0d. Inside City Limits 1 ☐ Yes ※☐ No	
Tecto		Charles		Co	bb Is	sland							
V = 9 V	10e. Street and Numb					10f. Zip Co				10g. Citizen of V	Vhet Coun	itry?	
23a 23a ral f	12014 Ne	ale Sou	nd Driv	7e		20	625			USA			
Tuner Internal	11. Marital Status	37	 Was Deceder Amed Forces 		,S. 13.	Was Deceder	t of Hispanic O Cuban, Mexice	rigin? (Speci en, Puerto Ri	fy Yes or No- cen, etc.)		e - Americ k, White,		
15-0020 n 72 hours efte neturel; or Heading Earth	1 Never Married		Armed Forces 1 X Yes 2 If If Yes, Give	WW	II	1□ Yes 2X	No Specify	y:		Specify	Whi	te	
21215-0020 d within 72 hours el jiene. Tran "natural", or tran "matural", or tran "matural", or tran "completed by I	3 Widowed 4	Divorced	Year or Dates	5:									
15-002 72 hours natural; sites Ex	(Specify	Decedent's Edu only highest grad	cetion e <i>completed)</i>		16e. Dece	e kind of work	Occupation done during mo retired)	ost of working	7	16b. Kind of Bu	usiness/inc	dustry	
within within then then complete	Elementary/Second	dary (0-12)	College (1-4o	r 5+)	_	_				Seafo			
	17. Father's Name (Fi	iret Middle Last)			1	Vaterm		her's Neme /	First Middle	Maiden Sumam			
ntal had be do do do do do do do do do do do do do	Austin R		Tavenr	ner						Tavenn			
2 should be filed end Mental Hygis a marked other aumatic event, To Be Cc				101	10h Mail	lina Address /6	1			r, City or Town,		Code	
d 2 should be filed with and Manual by spiene. The marked tother than traumatic event, the Manual by spiene. To Be Comp	19a. Informant's Nam												
Te, IV	Robert T		Jr./Sc	20b F	/41	L Ham1 osition (Name	Iton S	st. A	nnanda	ale, VA	City or To	03	
mit. Pages 1 ar mait. Pages 1 ar portant: If item y Injury or othe	₩ Burial 2 🗆	Cremation 3 DF		e c	cemetery, cre	emetory or other	er place)	10	/1 /00				
permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If flam 27 is marked other any injury or other traumatic event, and injury or other traumatic event, India.		Other (Specify)		Ма		ll Cem			/1/99	Marsh	all,	VA	
permit. Departrimporta	21. Signature of Fune	eral Service Licens	99				Address of Faci		ר א מידותו	L HOME	D A		
0.02 6 0	Large	/ C.	Elion	1009								•	
	23a. Part1. Enter the shock, or heart	disease, or compl failure. List only o	ications that caus	ed the deat line.	th. Do not en	iter the mode o	of dying, such a	s cerdiac or	respiratory ar	rest, 20	040	Approximate Interval Between	
Physician			_									Onset and Death	
/Medicaí Examiner	Immediate Cause (Fi disease or condition	inal	(and	lion	1246	lana	MAN	of .			30m		
	resulting in death)			Due to (c	or as a conse	equence of):					-	C	
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end	disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
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es thet the death igned by the ette be detached for by Physicia	Part II. Other significa	tributing to death	t I.	23b. Did t	obacco use co	ntribute to	the cause of death?						
Phot to									10	Yes 2 No	3 Prol	bably 4 Unknown	
signe I be of									040 11/00		24b W/	ere autopsy findings	
bean si should leted									perfo	an autopsy med?	av	allable prior to mpletion of ceuse	
The law require sate has been signate has been signated and Completed											of	death?	
The la									101	res 20 No	10	Yes 20 No	
certificate rector, pa	25. Wes case referre		Invelor .					ce of Deeth	Check only o	ne)			
hys his al di	1 Yes 2 N	0	lospital: 1 1 Inpa		ER/Outpatie					dence 8 □Oth		(v)	
	27. Manner of Death 1 ☑Natural	5 Pending	28e. Date of In (Month, E	njury Da <i>y Year)</i>	28b. Time Injury		. Injury at Work?		d. Describe h	now Injury occur	red		
tal or Attending P rs after death. rs Director: After t led in by the funers Certification:	2 Accident	investigation 6 Could not be	~		~	М	1 Yes 2						
or Attend after death Director: A I in by the f ertificat	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Plece of I building,	Injury - At he etc. <i>(Specil</i>	ome, farm, s	treet, factory, o	office	28	of. Location (5 City or Tow	Street and Numb vn, State)	er or Rura	I Route Number,	
Funeral Distriction of the property filled in								1					
within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	(Check only 2	☑ Certifying Phys ☐ Medical Exami	ner: On the basis	of examine									
thin 2 mplet	one)		and manner				icense number						
To the comple	29b. Signature and tit	ne or certifier	P 11							29d. Date signe			
	2/100	wwa	01 110)		–ע	11176			Sept	20	(1999)	
	30. Name and addres												
	Arthur	U.Woodd	y, MD 10)O Wa	shing	gton A	venue	P.O.	Box43	O La P	lata	,Md20646	

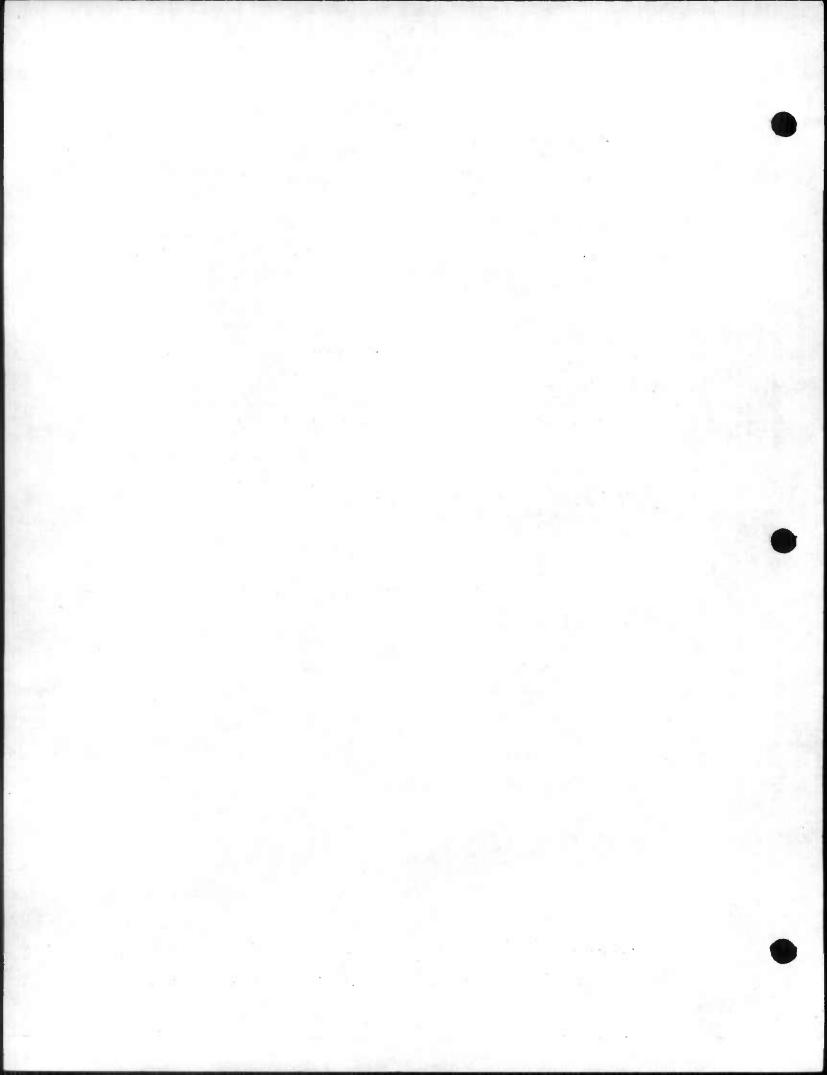
State Registrar



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			State of M	aryland	-	artment of F		and M		iene	9	31641		
	Division	1. Decedent's Name (First, Middle, La							h Day	Year	3. Time of Death			
Ę,	Physician /Medical	HAROLD	FRANKLI	N		WEAVER			eptember	24, 1	24, 1999 10			
	Examiner	4e Facility Neme (If not Institution, giv		and the second		4			cation of Death	4c. County		man I s		
_		Southern Marylan 5. Social Security Number 6. S	-	l loe (In yrs. las	t hirthday)	If Under 1 Year	If Under:	nton 24 Hrs.	8 Date of Birth			•		
ш	Funeral Director		M 2□F	56	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 0Ct. 10	1942	Pen	place (State or Foreign http:// nsylvania		
	y .	Usual Residence of Decedent		Tro or a										
	show sd.st	10a. Stete 10b. County	100	10c. City, 1								1 ☐ Yes 2XXNo		
	with the Ma t or 28a-f s be notified Director	Maryland Char	ies		Va 1 do	10f. Zip Code			1	0g. Citizen of V	Vhat Cour			
	death with the Maryland one 23s or 23s-f show constitut as notified at neral Director	6607 Coyote Cou	rt			20	0603			U.S.				
		11. Merital Status	12. Was Deceden	.0	13.	Was Decedent of H	lispanic Ori	gin? (Spe	cify Yes or No-		e - Americ k, White,	can Indian,		
20		1 Never Married 2 Married	1 X X es 2	No 1960.	-	1□ Yes XX No	Specify:			Specify				
21215-0020	led within 72 hours in Majerie. her then "naturel", o ht, the Medical Exam Completed by	15. Decedent's Ed	Year or Dates		6a. Dece	dent's Usual Occup	ation	-		16b. Kind of Bu	White			
215	Media Media	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4o		(Give	kind of work done of DO NOT use retired	during most	of working	9	Trans	porta			
S	Hygiens ther the ent, the	12			Aircr	aft Mech				U.S.		Air		
and	Be very	17. Fether's Neme (First, Middle, Last,							(First, Middle, I		(8)			
Maryland	Monitoria Menitoria Menito	Robert Louis Wea			19b. Mailir	ng Address (Street			E Living		Stata Zic	Coda)		
	and 2 a	Suzi Mills/Daught				Redhorse						20603		
ore,	-156	20a. Method of Disposition	1D	20b. Plac	e of Dispo	sition (Nama of natory or other place	ce)	-	Date	20c. Location -	City or Town, State			
Ĕ	Pages ment of ant: If the tury or o	1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	(y)			t Cremat		9-2	25-1999	Waldo	rf, N	Maryland		
Baltimore,	Separt Mepart mport my inj 658	21. Socialization of Funoral Engine Licenses 22. Name and Address of Facility The Huntt Funeral Home, Inc.												
	mew	JOHN P KNIS		01164	F	0. Box	156,	Walde	orf, Mai	ryland	2060	The second second second		
	Physician	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailura. List only one cause on each line. Approximate Interval Batweet Onset and Deat												
	/Medical	Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): CHRONIC RENAL FAILURE												
ľ	Examiner	resulting in death)	а,	Due to (or a	s a consec	quence of):	. , ,							
	e be executed sician and e bunal-transit		b. CHRO				FAI	LUI	20			2 mo.		
,	te be executed ysician and he burial-transit	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying		quence of):										
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89 >	requires that the death certifical been signed by the attending phy should be detached for use as the letted by Physician/Medicted by Physician/Medicted by Physician/Medicted by Physician/Medicted by Physician/Medicted	resulting in death) Last												
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o i	y the check	Part II. Other significant conditions of	ontributing to death	but not resulting	ng in tha u	nderlying cause giv	en in Part I		23b. Did tobacco use contribute to the cause					
, G	ned be date	CORONARY	ARTER	7 D	ISEF	tr E			1 Yes 20 No 3 Probab			bably 4 Unknown		
ord.	In he law requires that the death certifical cate has been signed by the attending phipage 2 should be datached for use as it Completed by Physician/Med								24a. Was a perfor		av	ere autopsy findings vailable prior to		
ecc.	S 2 0						·	-	1		of	ompletion of cause death?		
	Con Con								1 🗆 Y	es 2000	1 [☐ Yes 2☐ No		
of Vital Records, P.O. Box	certificant rector	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			- 2 DOA Oth	or:		(Check only or					
ō	Attendang Physician: wt death. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death	28a. Date of In	jury 28	Outpatier b. Time of	I 3LI DON	4UNU	-	ne 5 🗆 Reside 18d. Describe h			ry)		
loi.	ath.	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ey Year)	Injury		Yes 2	No						
Division	us or attending in a steer death. al Director: After tied in by the funeral Certification:	3 Suicide 6 Could not b 4 Homicide detarmined	28e. Place of It	njury - At home	, farm, str	eet, lactory, office		2	81. Location (Si City or Town		er or Run	al Route Number,		
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	to the hours effer death, within 24 hours effer death, To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) **Certifying Ph 2 ■ Medical Exam	nysician: To the besi niner: On the basis and manner s	of examination	and/or in	vastigation, in my o	na, data an pinion, daa	d place, e	nd due to the co ed at tha tima, d	ause(s) and ma ata and place,	nner as a and dua t	o the cause(s)		
	Within To the Complete of the	29b. Signature and titla of certifier	0 00			29c. Licens			2	9d. Date signed				
		Nah!	Path	MO		D5	22	89		9/2	5/8	5 %		
		30. Name and address of person who NALIN MATHUR, M	completed cause of ID, 11345	Pembro	oke S	Print) iq, Ste 1	04, W	aldor	f, Md	20603				
	State Registrar	31. Date filed (Month, Day, Year) SEP 2 8 19		trar's Signature	6.	Spark	2					- 81.18		

DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death SEPTEMBER 20, 1999 **Physician** 2:15 pm ALICE ROSE WILLIAMS /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Nama (If not institution, giva street and number) Examiner Prince Georges MANOR CARE LARGO LARGO If Under 24 Hrs. 5. Social Security Number If Undar 1 Yaer Birthplaca (State or Foreign Country) 7. Aga (In vrs. last birthdev) 8. Date of Birth (Month, Day, Year) **Funeral** Months Devs Hours Min 1□ M 2♥ F 018 30 7327 Yrs. Feb. 21, 1903 Canada Director 96 Usual Residence of Dacedani Pages 1 and 2 should be filed within 72 hours after death with the Menyland nent of Heelih and Mentle Ihyglene. Intil if Item 27 le marked other than "naturel", or items 23s or 28s-f show my or other transmit ovent, the Medical Exercities must be notified at my or other transmic event, the Medical Exercities must be notified at 10c. City, Town or Location 10e. Stete 10h Counts 10d. Insida City Limits Maryland Anne Arundel Holland Point 1 ☐ Yes 2 No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1010 Bayfront Avenue 20714 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14 Race - American Indian Bieck, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: à white 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Eiementery/Secondary (0-12) Collega (1-4or 5+) bookkeeper boat distributorship 18. Mothar's Nama (First, Middla, Meiden Sumama) 17. Fathar's Nama (First, Middle, Last) Be Alvin Cox Sidella Henley 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) P.O. Box 435, Holland Point, MD John Cox Williams / son 20714 20a. Mathod of Disposition 20b. Placa of Disposition (Name of cematary, crametory or other placa) Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Othar (Specify) Department of Important: If any Injury or Metropolitan Crematory 9-22-99 Alexandria, VA 22. Nama and Addrass of Fecility 21. Signetura of Funaral Servica Licensee William Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finel diseasa or condition rasulting In deeth) Examiner Due to (or as a consequence of) Examiner Ce ل-` physician and the burial-transit requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting In daath) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of) 98 esn Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to 24a. Wes an eutopsy performad? Completed complation of causa of death? s certificate hes b director, page 2 s 2 010 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: funeral director. 25. Was casa rafarred to medical axaminar? 26. Pieca of Death (Check only one) Be Hospital: 1 Yes No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Homa 5 Rasidance 6 Othar (Specify) After this 27. Manner of Daath 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 1 Natural 5 Panding after death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) filled in by 4 Homlcide 24 hours a **Certifying Physician To the best of my knowledge, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.

Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the cause(s) menner stated. 29a. Certifier edicai completely (Check only one) within 2 29b. Signeture 29c. Licanse number 29d. Data signad (Month, Dey, Year) complated causa of daath (Itam 23a) (Type, Print) Nema end address of person wh 6 9500 AMBUCCI

State Registrar

31. Data filad (Month, Day, Year)

SEP 23

32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene

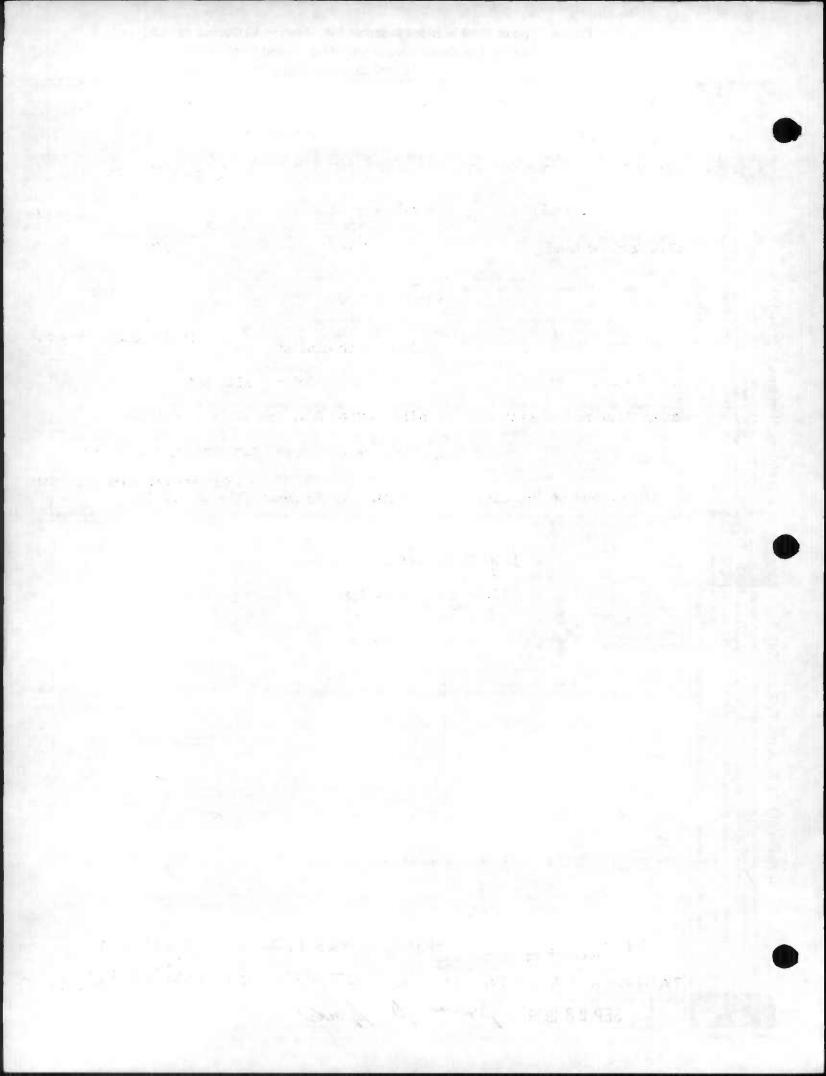
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edwin George Yakubowski Sr. 25 1999 Sept 5:30am /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 5712 Oakland Road Sykesville Carroll 5. Sociel Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 24 1927 Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1**X** M 2□ F Months Days Hours 230-24-7869 Yrs. Va. Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f ahow any injury or other traumatic event, the Wedital Examine must be notified anone. 10c. City, Town or Location Sykesville 10d. Inside City Limits Carroll 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5712 Oakland Road 21784 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
If Yes, Give 194 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1945-1 Never Married & Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: 1946 þ 3 Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Adm. Elamantary/Secondary (0-12) Collaga (1-4or 5+) computer specialist 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fether's Name (First, Middle, Last) Be Antonio Yakubowski Helen Lillie Smith 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 5712 Oakland Rd., Sykesville, Md 21784 19a. Informent's Name/Reletionship (Type, Print) Helen Yakubowski (spouse) 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State Lake View Memorial Park Burial 2 Cremation 3 Removal from State 9-28-99 Sykesville, Md 4 Donation 5 Other (Specify) 22. Nama and Address of Facility 21. Signature of Funaral Service Licensee Haight Funeral Home & Chapel Paige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting In death) Examiner Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceusa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Die o (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the ceues of death? been signed by the a should be detached 1 Yee 2 No 3 Probably 4 Unknown P 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed ils certificate has I director, page 2 s 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Placa of Death (Chack only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1. Naturel 5 Pending Investigation Injury 1 Yas 2 No rector: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicida To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Decartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Cartifiar Medical 29d, Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number MD 30. Nama and addrass of person who complated ceuse of death (Item 23a) (Type, Print) Reister KAWAJA 1777 TAHOORA

State Registrar 31. Date filed (Month, Day, Year)

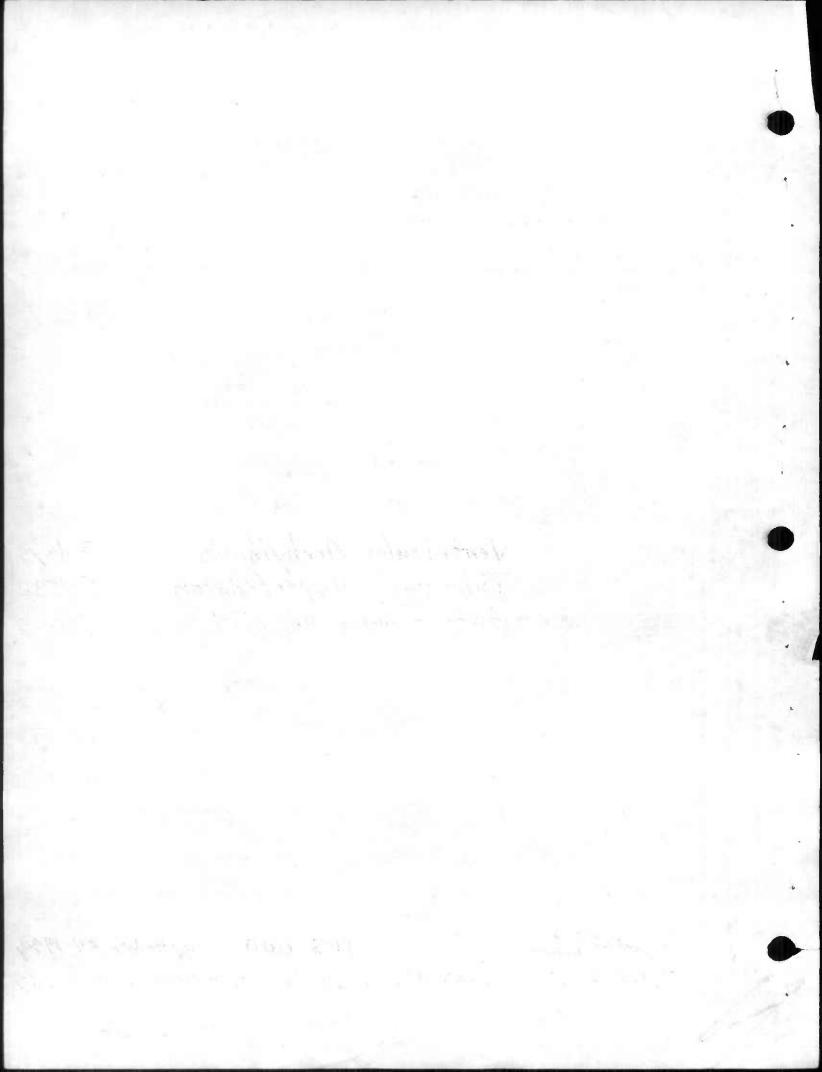
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32. Registrar's Signature



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		State of Maryla	•	cate of Death		Reg. No. 🤳 📗	3/644				
Physician /Medical	1. Decedent's Nama (First, Middla, Last TANE L)	2A	charias	2. Date of De Month Septem	ber 24,1	Year 999 2:22				
Examiner Funeral Director	THE Johns 1 5. Social Security Number 6. Sa	Hopkins +	Mo	4b. City, Town, of BAH minder 1 Year If Under 24 H this Days Hours Mi		Baltim					
show	Usuel Residance of Decedant 10a. Stata 10b. County		ity, Town or Location				10d. Inside City Limits 1 ☐ Yas 2 M No				
with the Market Start's to contract or				f. Zip Code 20112		10g. Citizen of V U.S.A.	What Country?				
72 hours after death with the Manyland natural; or items 23s or 28s-f show stell Examination matter motified at sted by Funeral Director	11. Marital Status 1 □ Never Merried 2 □ Married	12. Was Decedent Evar in I Armed Forces? 1 ☐ Yas 2 ☑No If Yas, Giva Yaar or Datas:		Decedent of Hispanic Origin? specify Cuban, Mexican, Pures III No Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Race Blace Specify	e - American Indian, k, White, etc. "White				
ed within 72 hours ygiene. Fr than "natural", It, The Medical Exi Completed by	15. Decedent's Edu (Specify only highast grad			Usual Occupation of work done during most of w OT use retired)	vorking		sinass/Industry				
Mental H Mental H arked ott attc even	17. Fathar's Nema (First, Middla, Last) Serfaas DeWind	2		Esther			a)				
1 and 2 sho Health and Im 27 is m ther traum	19a. Informant's Name/Ralationship (7) Kristy L. Zacharia 20a. Method of Disposition	/daughter		iner Lane, Woo		irginia 2					
permit. Pages Department of I Important: If Ite any Injury or o	1 Burlel 2 Cramation 3 F 4 Donetion 5 Other (Specify) 21. Signature of Funaral Sarvica Licens	Removel from Stata	acred Heart	Cemetery and Address of Facility ntcastle Funera	9/27/99	99 Manassas					
Physician /Medical	23a. Part 1. Entar tha diseasa, or compleshock, or heart failura. List only or Immediata Causa (Final	ications that caused the dea	4143	Dale Blvd., Dal	e City VA		Approximata Intarval Between Onset end Death				
Examiner	disaasa or condition resulting in daeth)	a Ventro Dua to	(or as a consequence	Hyper	tensia	3h	5 years				
ficate be physicial stree burners											
the school		ntributing to death but not ra	sulting in the underly	ring causa given in Part I.		Did tobacco use contribute to the cause of t					
aw requisite the second				24a. Wes an autopsy performed?		24b. Were autopsy findings available prior to completion of cause of death?					
certificate har rector, page	25. Wes case referred to medical				1□ Death (Check only o	Yes 2□No	1 ☐ Yas 2 ☐ No				
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	3 Suicide 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28b. Location (Street and Number or Richard City or Town, State)										
thin 24 hours thin 24 hours the Funer impletely fil		ner: On the basis of axamin and mannar stated.	ation and/or investig	ation, in my opinion, death or	ocurred at the time,	to the cause(s) end menner as stated. e time, date end place, and due to tha cause(s) 29d. Date signed (Month, Dey, Year)					
2	1			RES-UE	0 (septem	ber 24, 1999				
State	30. Name and address of person who co	ompleted cause of death (Ite	Norto	Wolfe Wolfe	St. Bo	Himor	e, MD 2/287				
Registrar	OCT 7 1	399 Jenes	J	Spall!							
			ORIGIN	IAL							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#10c PER F.H. G776 10-12-99 J.A 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dorothy C. Arnold October 10, 1999 0400 /Medical 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country)
Maryland 5. Social Security Number 8. Dete of Birth (Month, Dey, Mar 23 7. Age (In yrs. last birthday) **Funeral** Deys 1 ☐ M 2 € F Yrs. 212-36-8556 91 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Baltimore striced other than "natural", or hame 23a or 28a-f witcevent, the Medical Examiner must be notifie WESTVIEW 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1021 Collwood Road 21228 USA Funeral 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com; 16b. Kind of Business/Industry completed) Elementery/Secondery (0-12) College (1-4or 5+) 8th Homemaker Domestic marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Charles E. Biden Cecelia Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles E. Arnold/Son 1021 Collwood Road Baltimore, Maryland 21228 mportant: If Itam 27 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 ☑ Other (Specify) Entombmnt Woodlawn Cemetery 10/13/99 Baltimore, Maryland Signeture of Funerel Service Licenses 22. Name end Address of Fecility David J. Weber Funeral Homes, P.A. 5311 Edmondson Avenue Baltimore, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting In deeth) Lest Due to (or es e consequence of) Box 68760 certificate be Physician/Medical Due to (or as e consequence of): use been signed by the atte should be detached for P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificata 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Aftar To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 47683 10/11/95

completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

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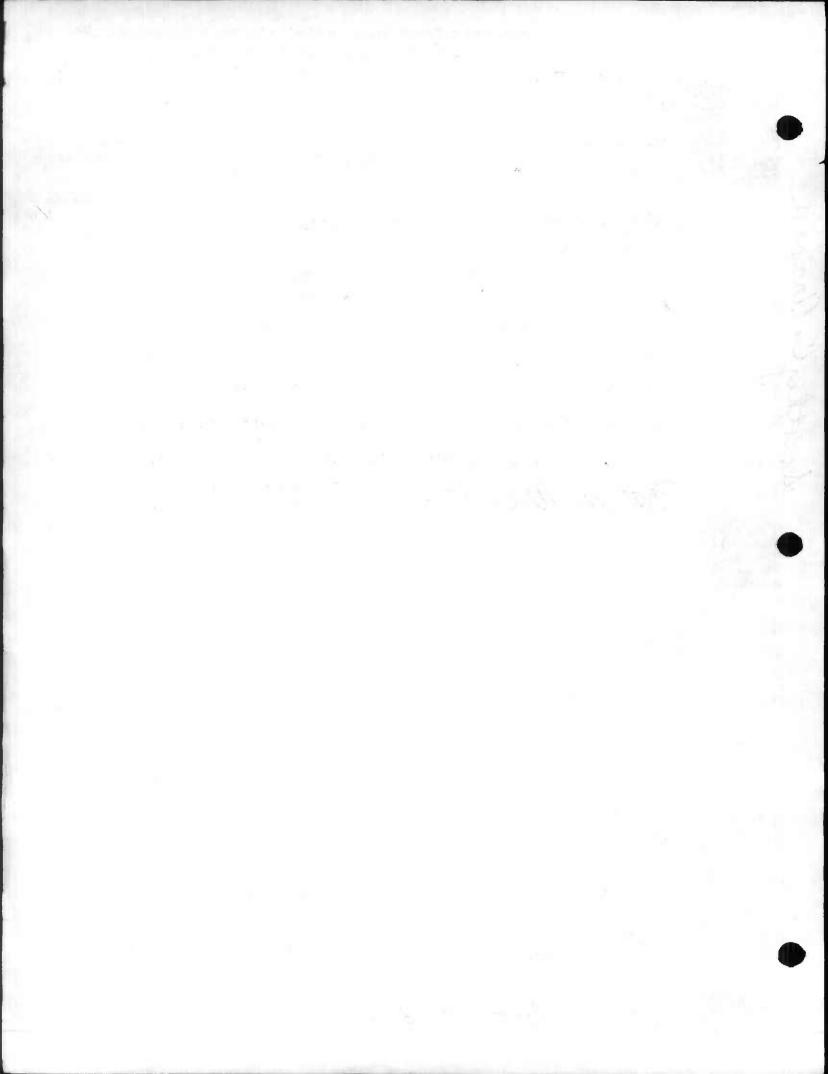
Restrotown

State Registrar 30. Name end eddress of person who

2 1999

Raymond Miller

31. Date filed (Month, Dey, Yeer)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Physician Month 9.10 Am GLTOBER 1999 Patricia K. Barlow-Armann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner NORTH ARUNDEL ANNE ARUNDEL HECPITAL GEEN BURNIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□ M 2⊠ F Director 213-84-6678 38 10, 1961 N. Carolina Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County Maryland Anne Arundel Odenton 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or harns 23a or the Medical Examiner must be 1346 Chapelview Drive 21113 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever In U,S. Armed Forces? 11 Marital Status ANBALL nours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Merried 1 Yes 2ENo Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bustness/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and Mental royal Department of Health and Mental royal Important: If Item 27 is marked other the new injury or other traumatic event, 20 9 Office Moving Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 88 Richard V. Barlow Hannalore Gelsebach 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 8400 Romancoke Rd. Stevensville, MD Sandra Hunt / Sister 12, Date 20b. Ptace of Disposition (Name of cemetery, crematory or other place) Oct. 20a. Method of Disposition 20c. Location - City or Town, State 1999 Glen Haven Mem. Pk. Glen Burnie, MD 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Pert1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician 21/2 YEARS METASTATIC BREAST CANCER /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner ettending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be deteched Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yes 25 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Physikin 24 hours effer death.
Turthe Funeral Director: After the completely filled in by the funeral 27. Manger of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier (Check only one) 29b. Signature-andfille of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 9 MD D45149 waho 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLEN BURNIE mb 21061 ONABAID -301 HOSPITAL DRIVE

Registrar

State

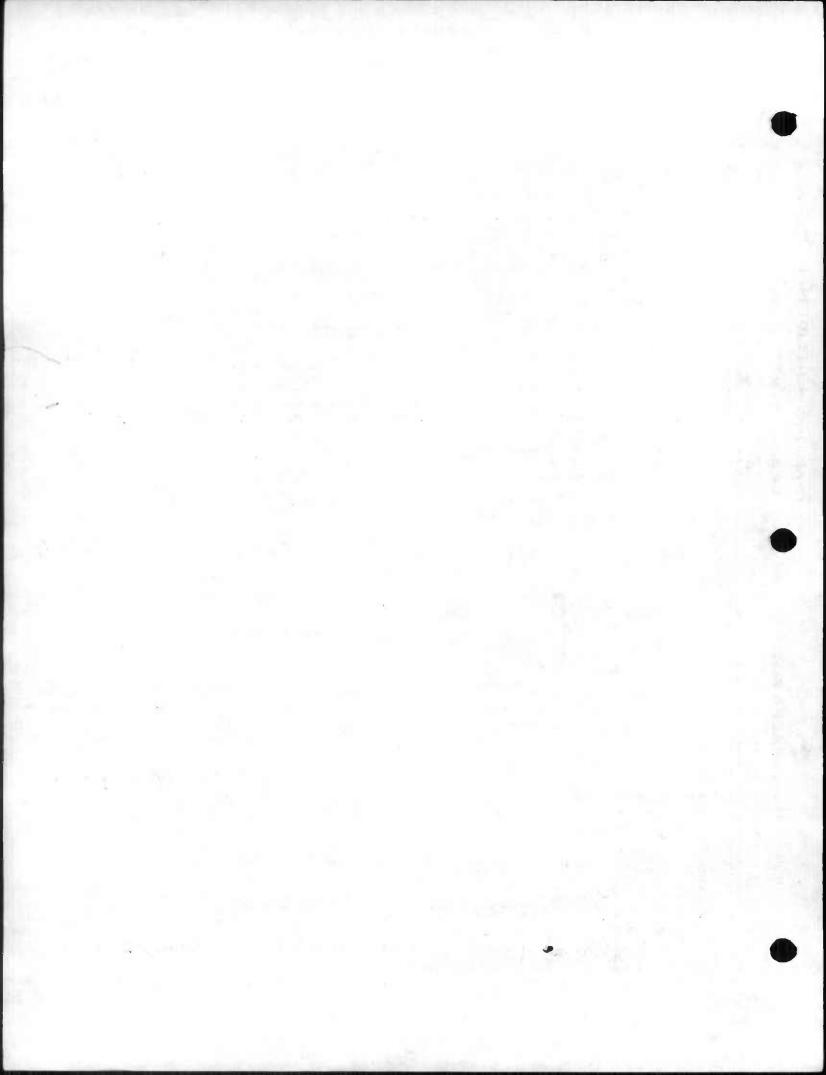
OCT 1 2 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

1. Span

ORIGINAL



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death October 06, 8:55 PM Sabastian Herbert Alberti 4s Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Cromwell Center Baltimore Co. Baltimore 5. Social Security Number If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Fig. Country) November 17,1916 awrence, Mass. If Under 1 Year Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) Hours 553-24-0289 10XM 20 F Yes Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limita 1 Yes 2 No Maryland Baltimore Co. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1885 Aberdeen Road Apt.B 21204 United States of America Race - Amarican Indian, Black, Whita, atc. 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1X Yes 2 No If Yes, Give Yaar or Datas: 1936-1940 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Captain n/a Merchant Marine 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Vincenzo Alberti Domenica Torrisi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Intermant's Neme/Reletionship (Type, Print) Mrs. Mary Grace Licata(Sister) 6838 Queens Ferry Road Baltimore, Maryland 21239-1225 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)Entonoment Dulaney Valley Memorial Gardens 10/08/1999 Timonium, Maryland 21. Signatura of Funaral Service Licensee Jeffrey L. Gair 22. Nama and Address of Facility Ruck Towson Funeral Home, Inc. the 1050 York Rd. Towson, Md. 21204-2515 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear tailure/List only one ceute on each line. Approximata Interval Between Onset and Death yartery deseas Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca ot): Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? your deserter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at

Director

Funeral

à

Completed

Be

2

with the Maryland

filed within 72 hours after

Hygiene.

permit. Peges 1 and 2 should be filed win Department of Heelth and Mental Physiers Important: if item 27 is marked other that any Injury or other treumatic event, that any Injury or other treumatic event, that any

Baltimore, Maryland 21215-0020

Box 68760

Physician/Medical py Completed 8

attending physician and for use as the bunal-transit Medical Certification: To

27. Manner of Death

1 Netural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

The law requires that the deeth certificate be executed Division of Vital Records, P.O. signed by t or Attending Physician: this After death. within 24 hours after death To the Funeral Director: completely filled in by the Hospital within 2 To the

29b. Signatura and titla of cartities

Registrar

h. Kan flowers 31. Date tiled (Month, Dey, Year)

5 Pending Investigation

6 Could not be determined

Marelu

28a. Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 81145ANDPIPCE CIRCLE

28b. Tima of

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1521022

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

10-7-99

28c. Injury at Work?

1 Certifying Physician: To lihe best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

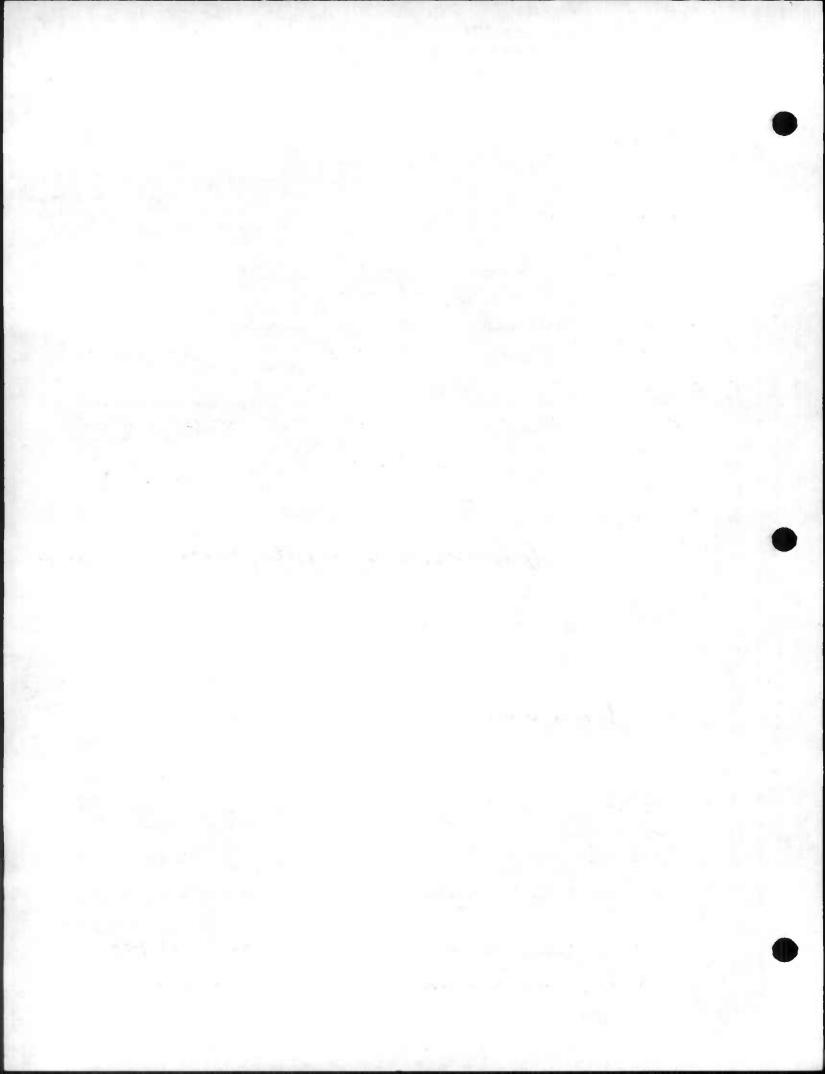
2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

1 ☐ Yes 2 ☐ No

Ster MD 212 36

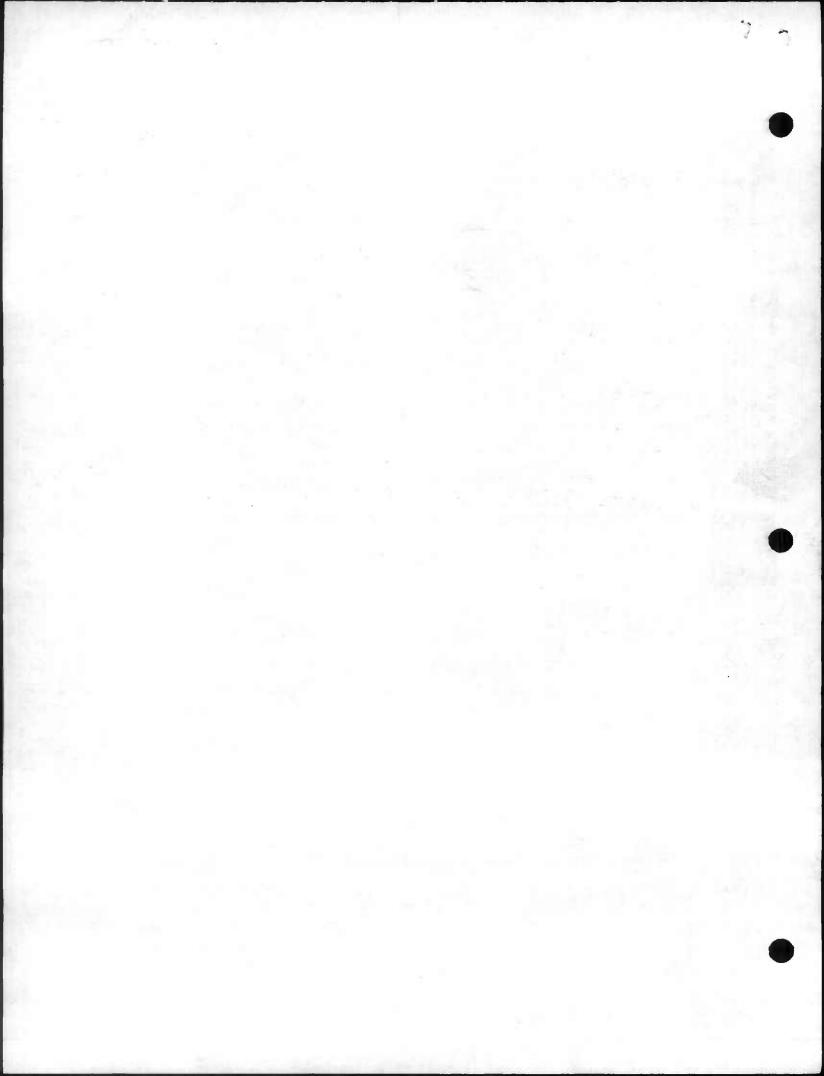
28d. Describe how injury occurred

32. Registrar's Signature



					Certifi	icate of	Death		F	Reg. No.5	3	648		
	1. Decedent's Nama (First, Mid		ARCHER						2. Data of Dea Month		Year	3. Time of Death		
Physicia /Medica	2/113/		oct					Day O 9	999	12:35 Pm				
Examine	An Casilla, blama III and Instituti				4b. City, Town, or Location of D BALT (MORE					1 Death 4c. County of Death BALTI MORE				
Funeral Director	5. Social Security Number 2/5-42-7596	6. Sex		In yrs. last bir		Undar 1 Year onths Days		24 Hrs. Min.	8. Date of Birth (Month, Day	, Year) 1912	Cour	place (State or Foreign htry)		
p	Usual Residence of Decedent										1			
ehow den	10a. State 10b. Count		,	Oc. City, Tow		norc	. 11.	1			1	10d. fnside City Limits 1 ☑ Yes 2 ☐ No		
72 hours effar death with the Maryland "natural", or flems 23s or 28s-f ehow edical Examinat must be notified at	Mq.	Ma. NA B						٦,						
	10e. Street and Number	3012 HARULEW AU								10g. Citizen of What Country?				
dea	3012 H/HA 11. Marital Status 1 Never Married 2 Ma	12. \	Vas Dacedent Eve	ar in U,S.	13. Was	Decedant of	Hispanic Ori	igin? (Spe	ecify Yas or No- Rican, etc.)	14. Rac	e - Amaric	can Indian,		
eurs efte.	3 ☑ Widowed 4 □ Divorce	rried 1	1 ☐ Yes 2 ☑No If Yas, Giva Year or Dates:			Yes 2 No			Specify: WI+ 17E					
	(Specify only high		mplated)	16a	(Give kind	s Usual Occu of work done VOT use retin	at of worki	ng	16b. Kind of Bi	usiness/in	dustry			
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d 2 should be filed th and Mental Hygi 7 Is marked other traumatic svent,	17. Father's Nama (First, Middle	, Last)				The state of the s			ne (First, Middle, Maiden Sumeme)					
Mental Mental arked or	HOHN	JOHN A. WEIL					ISABELLE					TING		
2 should and Men Is marke surration	19e. Informent's Name/Relation			196	. Meiling A	ddress (Stree	-	-		r, City or Town,		Code)		
C 20 00 F	GARNETH	M BR	own/Dr	149	301	2 HA	RUIE	w	4U. B.	9/LN	rd :	21214		
ges 1 and 2 sh it of Heelth and if item 27 is m or other traum	20a. Method of Disposition			20b. Pleca o	f Disposition	n (Neme of ry or other pla	aca)		Date	20c. Location -	City or To	own, State		
Pe Intro	1 Burial 2 Cremation 4 Donation 5 Other			Pleca of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State cemetery, crematory or other placa) MORELAND MEM. 22. Name and Address of Facility / Ex. FUNERAL He ME, Continued to the place of the place o							o Mot			
permit. Pe Department Important: eny Injury	21. Signature of Funeral Sprace Licensee 22. Name and Address of Facility / 52 FUNERAL Ite n									eme	=, (1470			
8258	Obstry mille 2527 HARFORD Ad BALL Md 21234													
Physician	23a. Part 1. Enter the distance, of shock, or head tellura. Liv	23a. Part 1. Enter the distance, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart teilure. List only one cause on each line.												
	Onset and Death													
/Medical	Immediate Cause (Final disease or condition CARDIAC ARRYTHMIA									HOURS				
Examiner	resulting in death) a. Due to (or as a consequence of):									(100,00				
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cien a														
licate be physicies the bu	that initiated events resulting in death) Last Due to (or as a consequenca of):													
2	2													
	Part II. Other signiffcant condit													
0 0 2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.								23b. Did tobacco use contribute to the cause					
that ded by deta	HYPOTHYRO		10				Yes 2 No 3 Probably 4 Unknow							
law requires that the as been signed by the 2 should be detached.	- THO THING								24a. Was	Was an autopsy 24b.		ere autopsy findings		
been s should									perfo	rmed?	00	vailable prior to emplation of causa death?		
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certificate	25. Was case refarred to medic	ol .					OC Disc	a of Dooth	101			1105 20140		
Physicism: rthis certific rel director,	examiner?	Hospi	tal: Inpatient	2 ☐ ER/Ot	destinat 2	DOA O	thor:		Check only o	lenca 6 Oth	or /Consi	6.1		
	27. Menner of Death	2	Sa. Date of Injury	28b.	Time of	28c. tnji				now injury occur		YI .		
offing th.: Afte of fun	1 Netural 5 Pend 2 Accident inves	ing tigation	(Month, Day Y	ear) I	njury I		ork?]Yes 2∐	No	20d. Describe from Injury occurred					
or Attending after deeth. Director: After I in by the funa	3 Sulcide 6 Could		Be. Placa of Injury	- At home, fa	ırm, street,	factory, office	1	- 1			ber or Run	al Route Number,		
tal or Attending P or after deeth. Old Director: After ti led in by the funare	4 Homicide	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, Stete)												
To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After thi completely tilled in by the funarel														
outh outh						29c. Licar	sa number			29d. Date signe	d (Month,	Day, Year)		
F 5 F 0	phant ME	DICALR	ESIDENT			R	ES 001	D		CTOBER	2 09	1999		
	30. Name and address of person		ated cause of deat	th (Item 23a)	(Type, Print	I)	5601	LO CH II		VD. BAL		*		
	BHARTI ABICHAND		April 100		THAN I	TUSTICAL	-	4						
State	31. Data filed (Month, Day, Yea.	2 199	32. Registrar's	Signature	19.	Space	Kal							
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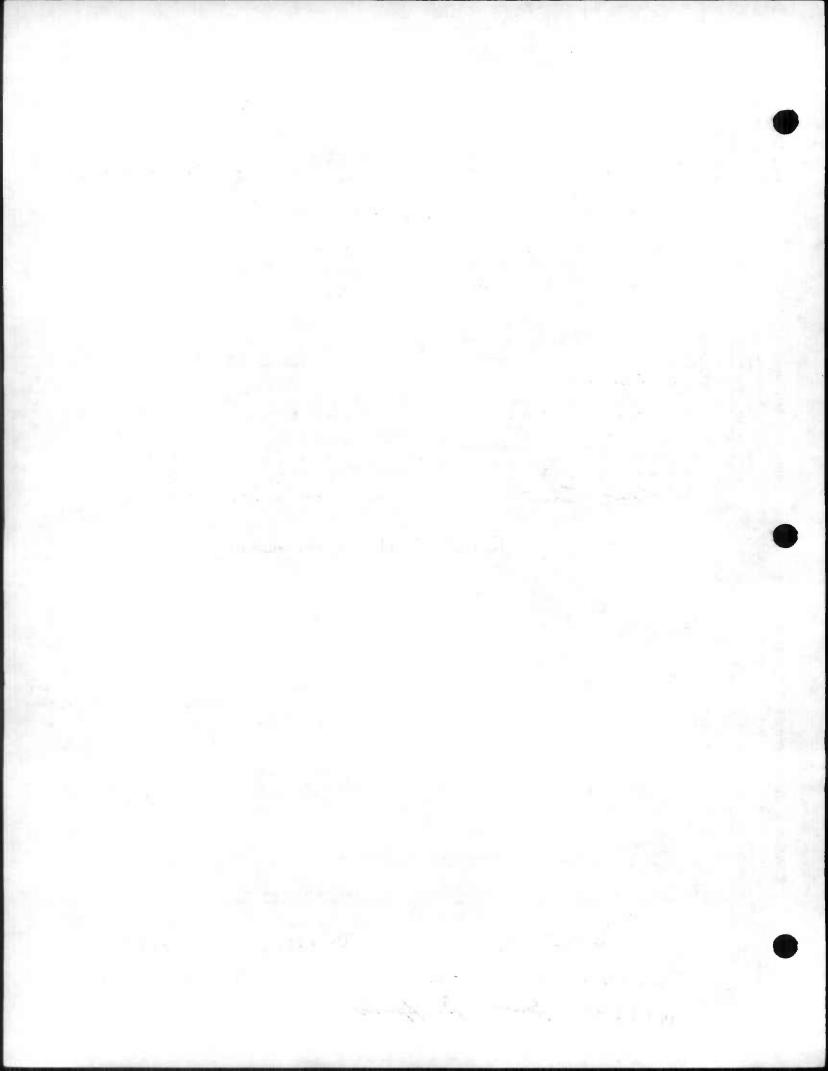
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 9 3 | 6 4 9

			C	ertificate d	of Death		Reg	. No.			
	1. Decedent's Nama (First, Middle,	Last)				2. Date Mon	of Death	Day	Year	3. Tima of Death	
Physician /Medical	Richard C. Alba	n Jr.							999	6.10hm	
Examiner	4a Facility Name (If not institution,				4b. City, Town, or Location of				of Death		
	Stella Maris Ho	spice Center			7	l'owson		Bal	timo	re	
Funeral Director	5. Social Security Number 215 74 3848	Sex 7. Age (In 120 M 2□ F 38	yrs. last birthda Yrs.	Months Da		Min. B. Date (Mon July	of Birth th, Day, Y	^(ear) 1961		lace (State or Foraign try)	
2	Usual Residence of Decedent	Lao	03 T.115								
Maryla drad at otor	Maryland Baltime		c. City, Town or Middle							0d. Inside City Limits 1 ☐ Yas 2 ☒ No	
vith the Me tor 28e-f a be notified Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Code 122 Covered Wagon Road 21221 USA									try?	
ral v	122 Covered Wago				USA						
within 72 hours after death with the Maryland era. The "retural", or fleme 23a or 28e-f show the Madinal Examinar must be notified a propleted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 ☑No If Yes, Give			igin? (Specify Yes n, Puerto Rican, at	or No- c.)	No- 14. Race - American Indian, Black, White, atc. Specify: White			
ed within 72 ho yglene. Nor then "neturn it, in the free Completed	15. Decedent's (Specify only highest		16a. De	cedent's Usual Oc	cupation ne durina mos	at of working	16	b. Kind of Bu	usinass/Ind	Justry	
The Party of the P	Elementary/Secondary (0-12)	College (1-4or 5+)	life	lifa. DO NOT use retired)						ation	
Para O	1 () 17. Father's Nama (First, Middle, La	et)	COLIC	ncrete Finisher			Construct			LON	
Mental H Mental H arked out arke avar	Dichard C Alban	•						y Finchman			
and 2 sho aith and 1 27 la ma er trauma	19a. Informant's Name/Relationship	o (Type, Print) rother)		9b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Sta 1516 Cox Street Baltimore, Md. 21211						Code)	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglens. Important: if hem 27 is marked other than 1 any Injury or other trauments avant, in a bance. To Be Compl	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	20b. Place of Disposition (Name of cemetary, crematory or other place) Oak Lawn Cemetery 10/13/1999 Baltin								
Departition of the same of the	21. Signature of Funeral Service Life	Sinsbe		22. Name and Ad Bruzdzi	nski Fu	neral Ho ern Avenu	me P	.A.	14 21	1 2 2 1	
	23a. Part f. Enter the disease, or co shock, or heart failure. List or	omplications that caused the	death. Do not						u. 2	Approximate	
law requires that the death certificate be associted as been signed by the attending physician and a 2 should be datached for use as the burial-transit apieted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due	to (or as a cons	sequence of):					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
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res that the death signed by the atter to be deteched for u			•		1 Yes 2 No 3 Probably 4 / Winknown						
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cartificate rector, pag Be Co	25. Was case referred to medical				26. Place	e of Death (Check	only one)				
N SE D	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpat	ient 3 DOA	Other: 4 No	ursing Homa 5] Rasidend	e 6 Kloth	Spice ar Specify	Ŕ	
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To the Hospital of within 24 hours at To the Funeral Di complataly filled it Certain Medical Certain Complexes and Certain Cer	29a. Certifier 1 Certifying (Check only one) 2 idedical Ex	Physician: To the best of my aminer: On the basis of axa and manner stated.	knowledge, de mination and/or	ath occurred at the investigation, in m	e tima, data ar ny opinion, dea	nd place, and due that the	to the caustime, date	se(s) and ma and place,	annar as st and due to	lated. the cause(s)	
To the somp	29b. Signature and title of certifier			29c. Lic	ense number		29d	. Data signe			
^	1 / wint			D	4372	5	10/11/99			9	
1/1	30. Name and address of person wh	o completed cause of death	(ttern 23a) (Tyr								
V	TARIQ MAHMO	10D 821.N	EWAN		+ 316	Baltin	rure	M	10 2	1201	
State Registrar	31. Date filed (Month, Day, Year)	Server 32. Registrar's	S. A	souls							



FREDERICK Records, BREITENOTHE Vital o Division

Baltimore, Maryland 21215-0020

State Registrar DHMH 16 Rev 6/95 ##

MICHAEL A. ZATINA, M.D.

Start (Manth Day, Year) 32. Registrar's Signature 900 CATON AVE BALTIMORE MD ZIZZQ 31. Dete filed (Month, Day, Year) 1 2 1999

30. Name end address of person who completed sause of death (Item 23a) (Type, Print)

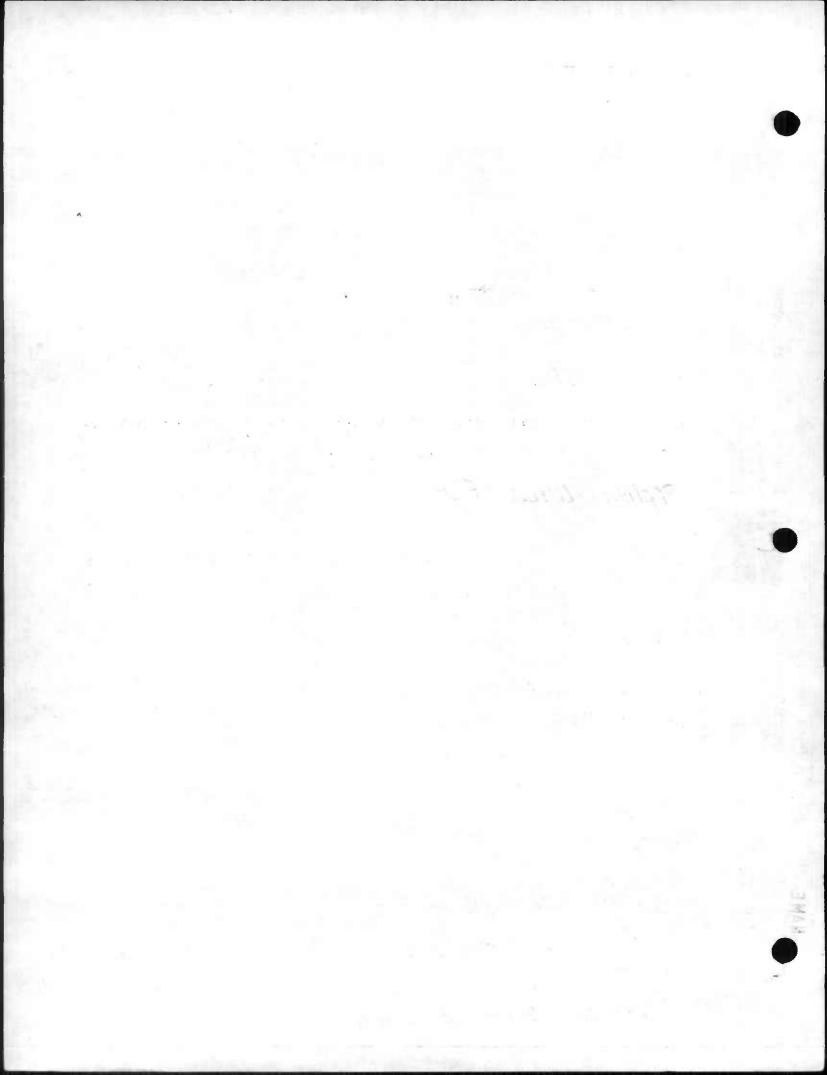
29b. Signeture and title of certifier

29c. License number

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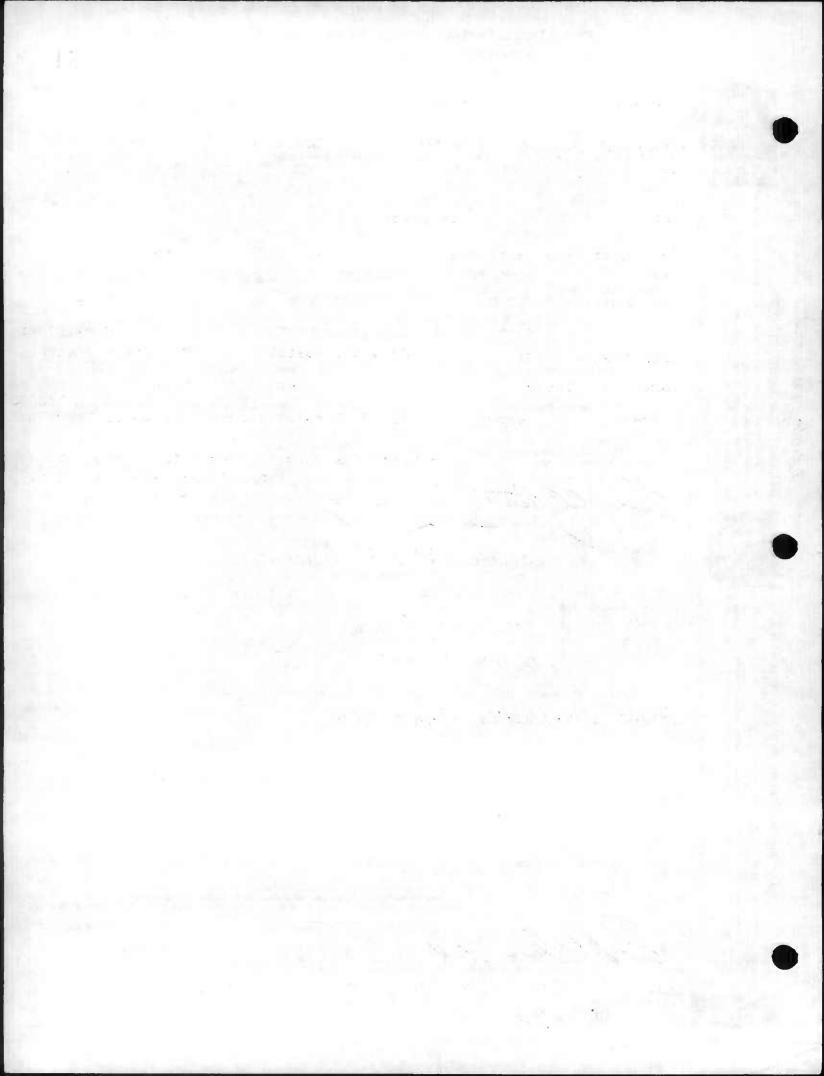
29d. Date signed (Month, Dev. Year)

OCTOBER



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner	Woodle)					2. Date of De	ath		3. Time of	Deeth
aminer		У		Brown	1			OCTOBE	R 6, 19	49	2130	m
eral	4a Facility Name (If not institution, give street and number) 4b. City, Tow						4b. City, Town, or I		4c. County			
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tor	227-66 Usual Residence	-0603 ¹⁰	XM 2□F	53	Yrs. Month			8. Dete of Bir (Month, De 02-0	7-46	9. Birthp Cour	place (Stete o	r Foreign
#	10a. State	10b. County				1	0d. fnslde Cl	ty Limits				
ctor	MD	NA		Balt	imore						1 Yes	2 No
23e or 28e-f show ust be notified at rai Director	10e. Street and No.		ederal Street			Zip Code 212	:13		10g. Citizen of V USA	What Cour	ntry?	
by Funer		ried 2 Married	12. Was Decedent E Armed Forces? 1 Yes 25 N If Yes, Give Year or Detes:			cedent of pecify Cub	Hispanic Origin? (S pen, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Rac Blac Specify	ck, White,	ean Indian, etc.	
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ompl	Elementary/Sec		College (1-4or 5	+)			Operato		Millir			
	12th G 17. Father's Neme	(First, Middle, Last)	NA						, Malden Suman			9
To Be	James	R. Bro	wn				Lou	Ethel	Maye			
E SE	19a. Informant's A	lame/Relationship (T)	ype, Print) Brown				deral S				0000	1213 land
any injury or other tr once.		cremation 3 F			of Disposition (final party) of the control of the		etery 10	Date -12-99	20c. Location -		e, MD	
in a		uneral Service Licens		1 di			ess of Facility B					
one	Man	mell	R				ch FH 1			-		
	232. Part1. Enter	the disease, or complant failure. List goly o	lications that caused	the deeth. [Approximat Interval Bet	e ween
ian ical ner	Immediate Cause disease or conditi resulting in deeth)	(Final	',)		taboli a consequence of		eidosis			1	Onset and I	
s the burial-transit			b. Theum	mitis		.41.				i		
edical Examiner	Sequentially list of any, leading to it ceuse. Enter Und Ceuse (Disease of	ongitions, mmediate erlying	Rossian	LAD.	a consequence of	00				2		
fical	Ceuse (Disease of that initiated even resulting in death)	Last		100	a consequence of	rf):						
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clan)1						
Be Completed by Physician/M	Severe sign	ficant conditions con	1 1/ 1	Huz	g in the underlying	ov couse g	iven in Part I.		tobacco use co Yea 2 No			Unknown
nould be								24a. Was	an autopsy ormed?	av	ere autopsy i eailable prior t empletion of o	0
ompl								10	Yes 2 12 No		death? ⊒Yes 2□	No
ctor, I	25. Wes case refe examiner?	/					26. Place of Dec	ath (Check only	one)			
To To	1 ☐ Yes 2 🗓] NO	Hospital: 1 DInpatie		Outpatient 3	DUA		1	idence 6 DOth		(y)	sy findings or to of cause
completely filled in by the funeral director, page 2 should be deteched for use Medical Certification: To Be Completed by Physician/W	27. Manner of Dee 1 Netural 2 Accident	5 Pending Investigation	28a. Date of Injur (Month, De)	Year) 28	b. Time of Injury M	28c. Inju Wo	ury at ork?] Yes 2 No	28d. Describe	how Injury occur	red		
pletely filled in by the funeral direction: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubulding, etc.	iry - At home :. (Specify)	, farm, street, fact	ory, office		28f. Location (City or To	Street and Numl wn, Stete)	per or Run	al Route Num	ber,
dical (29a. Certifier (Check only one)		sician: To the best of ner: On the basis of end menner sta	examinetion								1)
Me	29b. Signature	tigh of coother	0			29c. Licer	nse number		29d. Date signe	d (Month,	Day, Year)	
0	- Cu	My	an,	4.0.		89:	350		10/0	0/99	7	
Y	30. Neme end add	makialu	ompleted couse of de	eath (Item 23	(Type, Print)	16	Beneral	4050	ortal.			
	31 Date filed (Mo	nth, Day, Yeer)	32. Registra	ir's Signature	4	-		-				

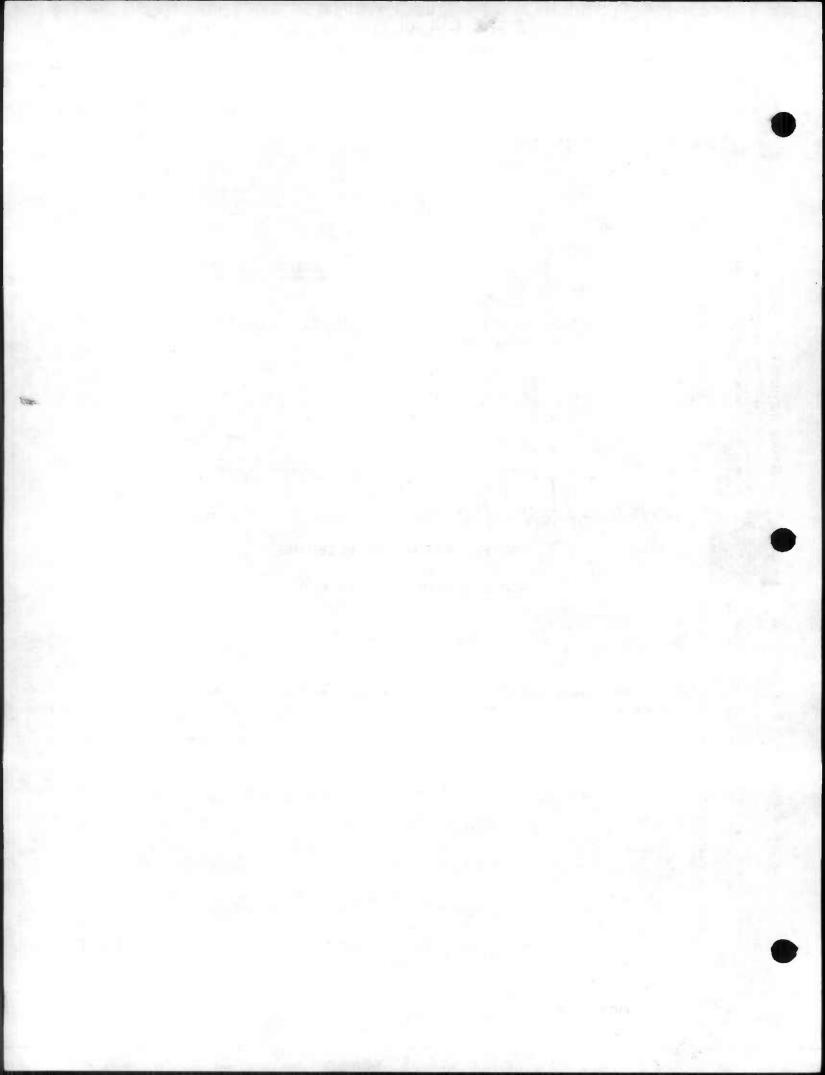


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** 09. 1999 MARY AGNES BOVA OCTOBER 10:45 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Baltimore Towson If Under 24 Hrs. If Under 1 Yaar 8. Date of Birth (Month, Day, Year) 12/12/1908 5. Sociel Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 DXF 90 216-32-0516 Director Virginia Usuel Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Neme 23s or 28s-f show the Medical Examiner must be notified at Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2702 Garnet Road 21234 U.S.A. death Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea.
Department of Haalth and Mental Hygiena.
Important: If flam 27 is marked other than easy injury or other traument Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forcas? 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Nevar Married 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Seamstress Matress Company 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Phillip Corso Nellie Fellaro OL 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Michael G. Boya/Husband 2702 Garnet Road Baltimore, Maryland 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State Parkwood Cemetery 10/13/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signety e of Funeral Service 22. Neme end Address of Fecility Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206 m deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final GASTRO-INTESTINAL BLEEDING disease or condition resulting In deeth) Examiner Due to (or es e consequence of): Examiner AORTO ESOPHAGEAL FISTULA ician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immadiete cause. Enter Undarfying Couse (Diseese or injury that initiated events resulting in deeth) Last Dua to (or as e consequence of): physician s the burial Box 68760 Physician/Medical Dua to (or as a consequance of): 888 USB detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE þ P ad 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Medical Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 TInpatient this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A 6 ☐ Could not be 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital 29a. Certifier 1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated. completely 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only 29b. Signature and little of contrile 29c. License number 29d. Data signed (Month, Dey, Year) D37254 10 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) BOON P. LIM, M.D., 7601 YORK ROAD, TOWSON, MARYLAND 21204 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 1999 Registrar

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** October 9, 1999ar Isabella M. Benevides 1:05 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Knollwood Manor Nursing Home Millersville Anne Arundel If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) Dete of Birth (Month, Dey, Year) **Funeral** Deys Months Hours 576-48-0021 1□M 2√F 96 Yrs. Director June 12, 1903 Hawaii Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Severn Director 28a-f 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? or Itsms 23a or 8109 Equestrian Drive 21144 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Reca - American Indien, Black, White, etc. filed within 72 hours after Yes 2 No f Yes, Give 1 Nevar Married 2 Married 21215-0020 Aq 1 ☐ Yes Y No Specify: Specify: White 3 Widowed 4 □ Divorced Yeer or Detes: Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own HOme altimore, Maryland 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) h and Mental I Be Pages 1 and 2 should be nent of Health and Mental Manuel Nasciemento Isabella Cabral 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Nem 27 is any Injury or other trau 2056. John Benevides/Son 8109 Equestrian Dr. Severn, Md 21144 20b. Plece of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Steta Commetery, crametory or other plece)
Homelani National Cem. Oct. 19, 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Hemoval from Stata Hilo, Hawaii 4 Donetion 5 Other (Specify) 1999 21. Signeture of Funaral Service Licensee 22. Name end Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilura. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final neumoma disaase or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, it any, leeding to immadiele cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequenca of) been signed by the e should be detached Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown extrase ear 79 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy complation of causa of death? hes 1 ☐ Yas XX No 1 ☐ Yes 2 ☐ No this certificate Depital or Attanding Physician: hours after death. funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2√ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Yaer) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigetion the 6 Could not be determined To the Hospital or Atta thin 24 hours after de To the Funeral Directo 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ★ KCertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated.

3. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated.

3. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

4. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

4. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

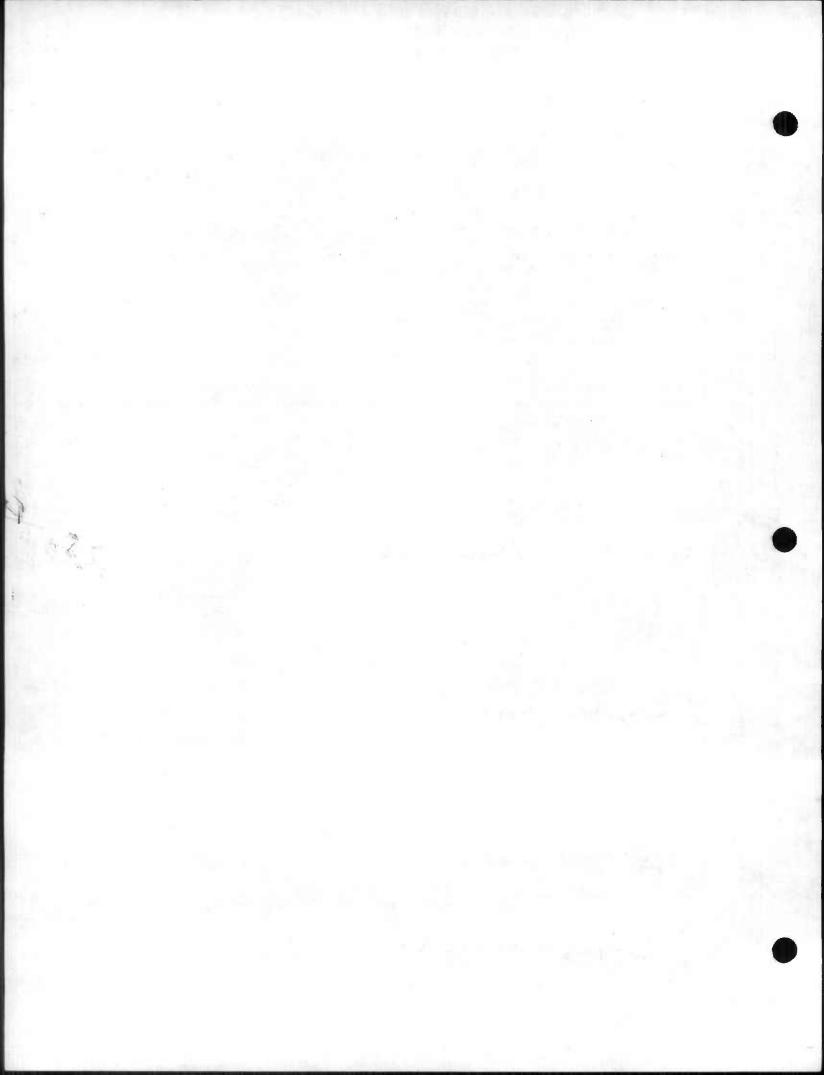
5. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

5. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

6. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

7. **To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated.

8. **To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, end deeth occurred et the time, date end plece, edical 29e. Certifler (Check only one) 29b. Signatura and titla of certifier 29c. Licensa number 29d. Data signad (Month, Dev. Year) Attender Doctor D21864 October 11, 1999 30. Name and address of person who completed cause of deeth (Item 23s) (Type, Print) 8109 Richie Hwy. Pasadena, MD Chackumkal Cyriac M.D. 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State Registrar OCT 12 1999



29d. Dete signed (Month, Day, Year)

"natural", or liams 23s or 28s-f show death with Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0020 Separtment of Health and Mental Hygingortant: If Item 27 is marked other

Physician

/Medical

Examiner

Be Completed by Funeral Director

2

Funeral Director

Physician /Medical Examiner

the attending physician and the for use as the burial-transit To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Directors After this certificate has been signed by the attending physician and completely filled in by the turnest director, page 2 should be detached for use as the burish-transit completely filled in by the turnest director, page 2 should be detached for use as the burish-transit signed by t d be detach

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

5. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday) Yrs.	Months Months	Days	Hours	Min.	8. Date of Bir (Month, Di	th ly, Year)	Birthplaca (Country)	State or Foreign
350-12-0698 Usuet Rasidence of Decedent		IM SUF	1⊠M 2□F 75						May 21		Illino	ois
10a. Stete	10b. County		10c. Ci	ty, Town or Lo	cation						10d. tn	side City Limita
Maryland		N/A				Ва	1timo	re C	ity		11	Yes 2 No
10e. Street and Nur	mber				10f. Zi	p Code			T	10g. Citizen of	What Country?	
2100 D	oston S	Stroot	#410					2123	1	Unite	d State	5
11. Meritel Stetus	OS COII à		cedent Ever in U	I.S. 13. V	Was Deca	dent of H	lispanic Ori				e - American Inc	
		f Yes, ape	cify Cube	an, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	Blac	ck, White, etc.				
1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Detes: ₩iv				II I	1 🗆 Yea	2⊠ No	Specify:			Specify	y:	White
(Spec	15. Deceden	t's Education st grade completed	ŋ	16a. Deced	kind of wo	ork done	during mos	t of work	ing	16b. Kind of B	usinass/Industry	
Elementary/Seco	ondary (0-12)	College	(1-4or 5+)		DO NOT							
12 Ye	ars			Pol:	ice 0	ffic	er			Law	Enforce	ment
17. Father's Neme	(First, Middle,	Last)					18. Mothe	er's Neme	First, Middle	, Maiden Sumen	18)	
Edward	Paul 1	Burger					Lu	cill	e Vero	nica Ash		
19e, Informant'a Ne		F ()F	Wife							er, City or Town,		
Mrs. A	rling 1	Burger		2108	Bos	ton	St.	#410	Balt	imore, M	aryland	21231
	Cremetion	3 ☐Removel from	n State	Place of Dispo cemetery, crer	natory or	other plac		1 0 41	Dete		City or Town, S	
4 Donation			H1.	lltop S					3/1999	Towso	n, Mary	land
21. Signeture of Fu	unerel Service	Licensee			uda-	Ruck		ral		Dundal Maryland		
23a. Part Shter ti	he diseese, or	complications that	caused the dea								Appr	oximete
shock or hea	rt feilure. List	only one cause on	eech line.								Inter Onse	vet Between at and Death
Immediate Cause (disease or condition resulting in death)	(Finel	DIA	BETE	3 ME	441	TU	IN	SUL	LINE	DEPE	NOEN	T
resulting at death)		PE	Pue to (or es a consec	quence of)	VA	SCL	16	an 2	TUSUI	FICIE	204
Sequentially list confrant, leading to irr cause. Enter Under	enditions,	6.	Due to (or as e conseq	luence of)		\sim			_		
cause. Enter Unde Cause (Disease or that initieted events	erlying Injury	c. 4	ANU	REN	A	R	114	1+1		007	-	
resulting in death) I	Last		Due to (d	or as a conseq	uence of):						ţ.	
		d									1	
Dark II. Other steeld	Donat condition		donate have and an	valetin or the edition of			un in Bod i		22h Did	tobacco use co	manthus a de dhie e	arran of death?
Part II. Other signif	ricant conditio	ris contributing to	oeath but not res	suiting in the u	ndenying	cause grv	en in Per			١.		
									1 10	Yes 25 No	3 Probably	4 Unknown
				. 1						an autopsy ormed?	available	on of cause
									10	Yes 2 No	of death	
25. Was case refer	red to medical						26 Place	a of Dest	h (Check only	/		
examiner?	,	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 D	OA Oth	or si			Idence 6 Ott	nar (Specify)	
27. Manner of Death	4.1	g 28a. Det	a of Injury onth, Day Year)	28b. Time of Injury		28c. Injur Wor	y at			how Injury occur		
2 Accident 3 Suicide 4 Homicide	6 Could detarm	not be 28e. Plac						-	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)			

State Registrar

31. Date filed (Month, Day, Year) 1999 **DHMH 16 Rev 6/95**

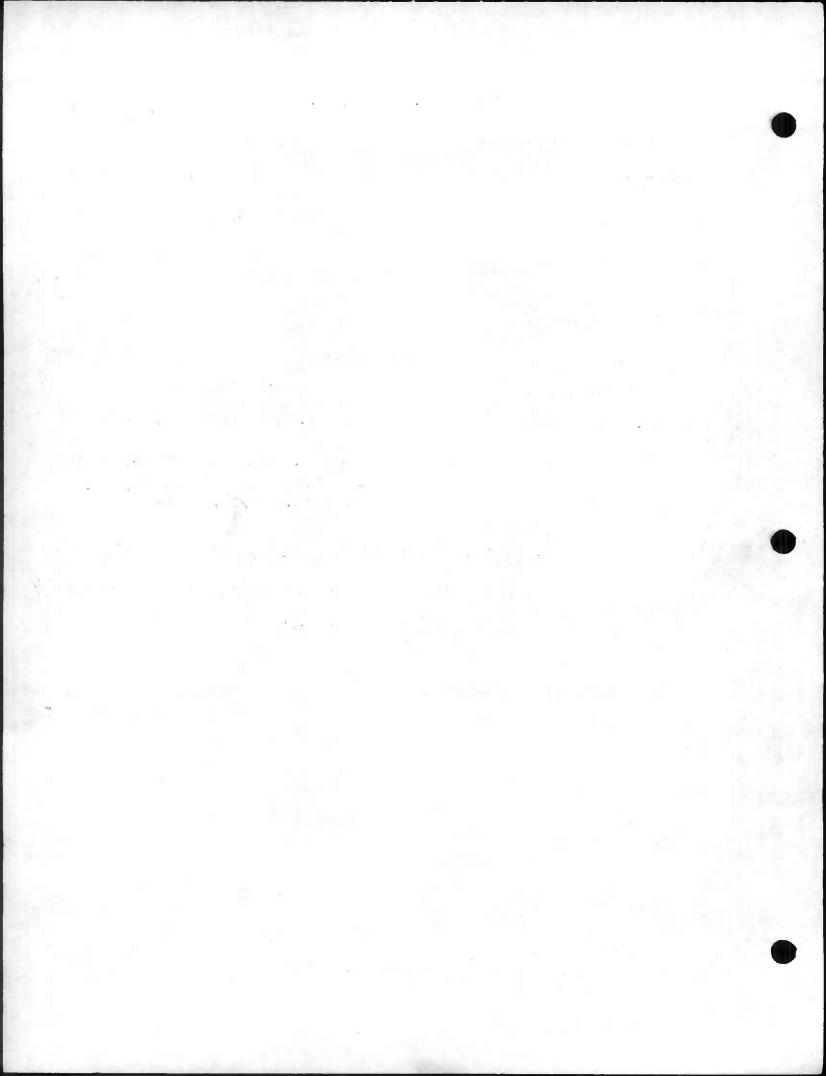


completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

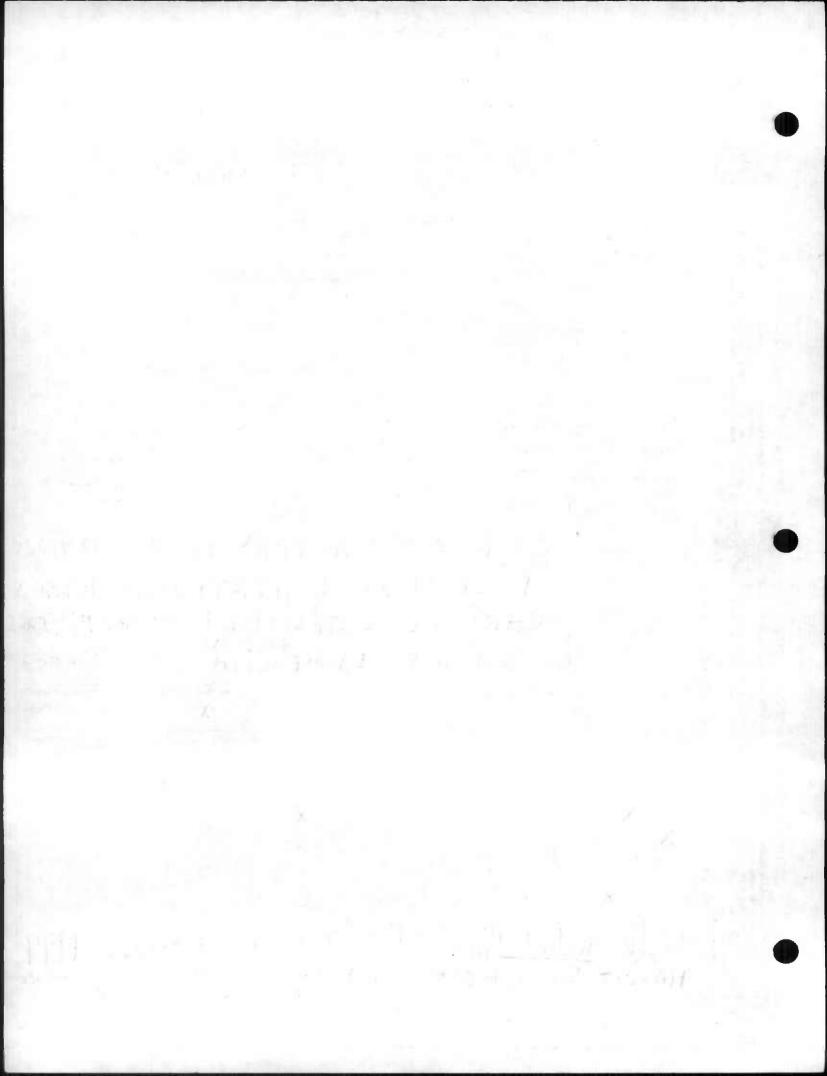
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Rej	J. No.	31655								
Physician	1. Decedent's Neme (First, Middle, Last)	2. Date of Death Month	Dey Year	3. Time of Deeth								
/Medical	Hyacinth V. Baytos 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Low	October	6 1999 4c. County of Deal	1:15 P.M.								
Examiner	Genesis Eldercare Hammonds Lane Center Baltimore											
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, 1	Anne Arundel Birth Day, Year) 9 Birthplece (State or I Country)									
Director	220 03 9903 1 M 2 X F 79 Yrs. Months Days Hours Min.	Oct. 9,	aryland									
Man Man	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
the Mar 28s-f a notified	Maryland N/A Baltimore			1⊠ Yes 2□No								
E 58 G	10e. Street end Number 10f. Zip Code 21225	10	Og. Citizen of Whet Country? U.S.									
0020 ours after death val., or terms 23 Examiner must.	11. Marital Status 1 □ Never Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Force If Yes, Sive Year or Dates:	city Yes or No- Rican, etc.)	14. Race - Ame Bleck, Whit Specify:									
1 21215-0020 ed within 72 hours al ygleno er than "nefunal; or are tt the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) Iffe. DO NOT use retired)	19	6b. Kind of Business									
	8th Salesclerk 17. Father's Name (First, Middle, Last) 18. Mother's Name		ag Store									
Maryland 42 should be file in and Mental Hy The marked offer treumelic event		llian Sh										
A Durant	19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	l Route Number,	City or Town, State,	Zip Code)								
Malina 2	Barbara Morris / Daughter 2A Schneider Drive	Sykesvil	le, Maryl	and 21784								
Baltimore semit. Pages 1. Papartment of Ha mportant, if Isa my Injury or oth sing.	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) HOLY Redeemer Cemetery		Oc. Location - City or Baltimore	Town, State Maryland								
Balti Departr Imports any inju	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225											
Physician	234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart feilure. Use on your cause on each line.	r respiretory arres	it,	Approximete Intervel Between Onset and Death								
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death) CORONARY ARTER	Y DI.	SEASE	124 EARS								
owcuted n end ist-transit Examiner	Sequentially list conditions Due to (or as a consequence of): Due to (or as a consequence of):	RTE	NOIZM	184 EARS								
2 Page 2	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initited events require in death) Lest	VE PU	LMONAR	YISYEAR								
	resulting in death) Last d. SEMILE DEMENT	LA		3 YEARS								
death cert eath of for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tob	acco use contribute	to the cause of death?								
ds, P.O. Box (ires that the death certif signed by the attending id be deteched for use a d by Physician/Me		1 Yes 2 No 3 Probably 4 Unknown										
Cord v require been s should		24a. Wes an perform	ed?	Were autopsy findings available prior to completion of cause of death?								
		1 ☐ Yes	2 No	1 ☐ Yes 2 ☐ No								
Vita	25. Was case referred to medical examiner?	(Check only one	, ,									
F 4 45 F			ce 6 Other (Spe	ecify)								
ding i	1 Natural 5 Pending (Month, Day Year) Injury Work?	8d. Describe hov	v injury occurred									
Division of the or Attending P or a the death. al Director: After the transment of in by the tuners Certification:	2 Account	281. Location (Street and Number or Rural Route Number, City or Town, State)										
Hospi A hou Funer tely fill	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, e Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau	use(s) and manner as e and place, and due	s stated. a to the cause(s)								
To the within a To the comple	29b. Signature and title of certifier Attendity 29c. License number	50 ()(d. Dete signed (Moni	th, Dey, Year)								
W.	34 Marine approach research person shoped mobiled fause of death (Horn 230) (Type, Print) RITCHIE	HIGHY	JAY BA	LITIMORE								
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signature	1149-		3								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death **Physician** OCTOBER, TO, 1999 Frances V. Boyd 1530 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner St. Agnes Hospital Baltimore N/A If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Hours Months 1□M 25 F 218 42 1008 Director 56 Nov. 16, 1942 Maryland Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland 1 Ves 2 □ No Director N/A Baltimore 280-1 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ 238 2820 Waterview Avenue 21230 U.S. Funeral Berns 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black Whita atc. filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Never Married 2 Married Baltimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: ğ 3 Widowed 4 Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Maryland Cup 10th 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be fit ment of Health and Mental Health and Mental Health art; if them 27 is marked oth lury or other traumatic even Be Cora M. Spencer Frederick J. Reuwer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Connie Dixon Daughter 404 Irene Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burlal 2 Cramation 3 ☐ Removal from State 10/13/99 Towson, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Hilltop Service Corp. 21. Signatura of Funaral Sarvice Licensee 22. Name and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, nock, or heart fallure. A st only one cause on each line. Approximata Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final 5 days DNEUMONIA diseasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examine ician and bunal-transit Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No obstructive pulmonary Records, py 24b. Ware autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 21 No certificate of Vital Be 25. Was casa ralarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 27. Mannacel Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding invastigation Division or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accidant 24 hours after deat Funeral Director: 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar within 24 hor To the Fune completely fi (Check only one) 29b. Signature anatitle of certifian 29c. License number 29d. Date signed (Month, Day, Year)

D47353

October 10, 1999

900 Caton Avenue Baltmore, Maryland 21224

Registrar

Boyd

Frances

OCT 12

Jon FAICK MD

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

St. Agnes

Hus pital

32. Registrar's Signature

Shering month

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month Year **Physician** Baver Bernadett 05 OCTOBER 1999 21:01 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) **Examiner** N/A THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 9. Birthplece (State or Foreign Country) Maryland If Unu if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 2□F Devs Yrs. 217-30-3890 Director 2-1-1935 Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner name be notified at 1 Yes ZONO Maryland Baltimore Stevenson Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1531 21153 Greenspring Valley Road S. A. permit. Pages 1 end 2 should be filed within 72 hours etter death v Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a any Injury or other traumatic event, the Medical Examples maintable. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1□ Yes 2□ No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Collega (1-4or 5+) Elamentary/Secondary (0-12) Counselor Education 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Joseph Bauer Teresa Topolski 2 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 1531 Greenspring Valley Road, Stevenson, Maryland Sr. Marie Kelly S.N.D. 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Ilchester Cemetery 20c. Location - City or Town, State 20e. Method of Disposition 1 □ Buriel 2 □ Cremation 3 □ Removel from Stete 10-9-99 Ilchester, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funarel Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, 1050 York Road, Towson, Md

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204 Approximate Intervel Between Onset and Deeth **Physician** /Medical Immedieta Cause (Final liver disease end stuge diseese or condition resulting in daath) Examiner Due to (ours e consequence of): Examiner cholongifis sderosing lew requires that the death certificate be executed ettending physician and for use as the bunel-transit Sequentially list conditions, if any, leeding to immediate causa. Enter Underlying Ceuse (Disaasa or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, failure Physician/Medical Due to (or as e consequenca of): gastrontestinal bleeding 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 ☑ Unknown 1 Yee 2 No Lowel disease 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Was an autopsy performed? Completed certificate hes birector, page 2 s 1 ☐ Yes 2 No 1 Yas 2 No To the Hospital or Attending Physician: funeral director, 25. Wes cese referred to medical exeminer? 26. Pieca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Data of Injury (Month, Dey Year) 27. Mannag of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicida 24 hours a 1 Certifying Physician: To the best of my knowledga, deeth occurred at the tima, date and place, and dua to the cause(s) and manner as stated. 29e. Certifier Medical completely 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and plece, and due to the ceuse(s) and menner stated. (Check only within 2 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier yollege M october 5, 1999 RES-000 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Holfe street, Baltimore, MD 21287 chatterjed) 600 North 32. Rigistrer's Signature State

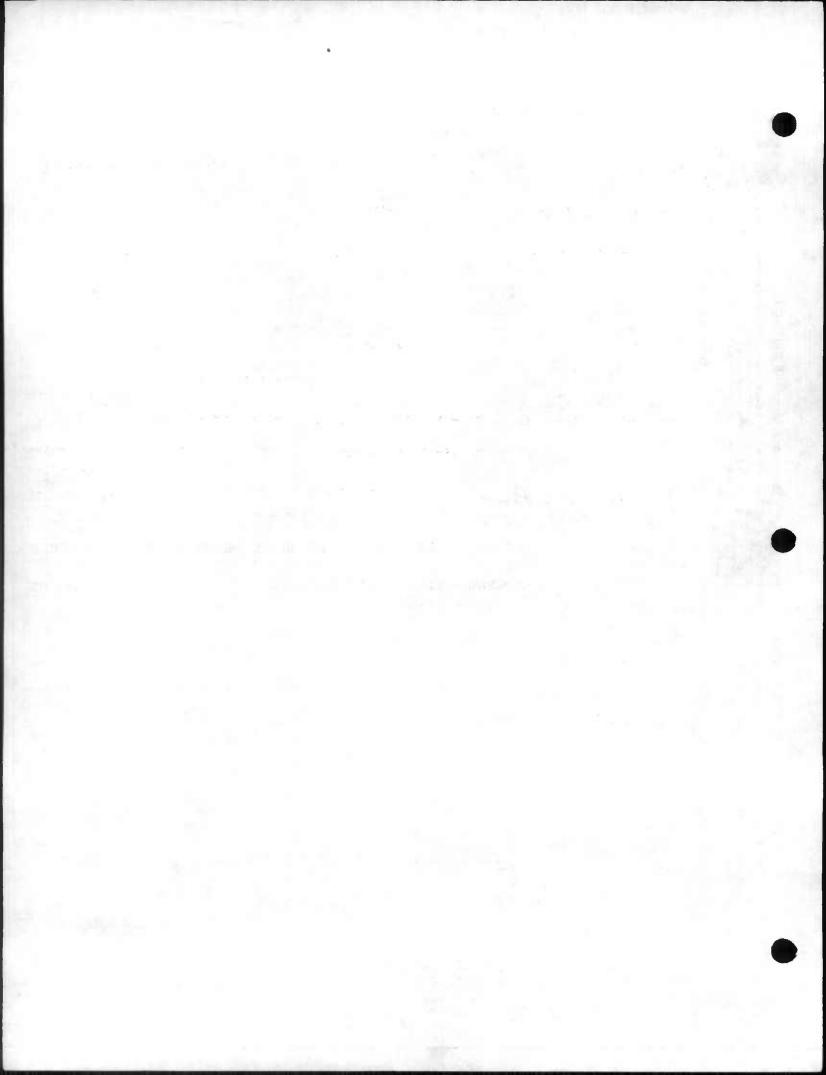
DHMH 16 Rev 6/95

Registrar

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	\sim		State of Maryland	Certificate of		Reg. N		21652			
		1. Decedent's Neme (First, Middle, La	ist)	2. Date of Death 3 Time of Death							
я	Physician	Cambridge VI v	2 - 1 1	Dr.	OCTOBER Ø5. 1999 8:47 PM						
5	/Medical	Sophia W. H	daltozer ve street and number)	4b. City, Town, or Location of Death 4c. County of Death							
	Examiner	Saint Joseph 1		Towsor		Balt	imore				
	Funeral S Director	193-14-5703	Sex 7. Age (In yrs. I	Ast birthday) If Under 1 Yea Months Day:		8. Date of Birth (Month, Day, Year 4-6-1924	thplace (Stata or Foraign ountry) nnsylvania				
	1/2 = 13	Usuel Residence of Decedent 10a. State 10b. County	100 Cib	y, Town or Location				10d. Inside City Limits			
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Maryland Baltimore Lutherville 1 Tves									
		10e. Street end Number		10g. C	10g. Citizen of What Country						
	5 6 70	34 Haddington	Road	2109	3		U. S. 1	Α.			
020	urs after des	11. Marital Status 1 Never Merried 2 Merried 3 MWidowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	S. 13. Was Decedent of It Yes, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Raca - American Indian, Black, White, etc. Specify: White				
21215-0020	min 72 hours	15. Decedent'a E (Specify only highest gn Elemantary/Secondary (0-12)	ducation ade completed) Collega (1-4or 5+)	life. DO NOT use retir	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			/Industry			
2	SPECIAL SPECIA	12		Manicurist	I		Emmerson Hotel				
Maryland	to Be	17. Father's Name (First, Middle, Last Thomas Wag	n gner		18. Mother's Name (First, Middle, Maidan Surname) Virginia Lear						
ary	of party	19a. Intormant's Name/Relationship ((Type, Print)	19b. Mailing Addrass (Street	et and Number or Run	al Routa Number, City	or Town, Stata,	Zip Coda)			
	Sep 2	Mrs Marie Elaina	Weisner (Dtr.)	4125 Abbing	ton Terrac	e, Wilming	ton, N.	C. 28403			
altimore,	Papes 1.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 1 Dete 20c. Location - City or Town, State cemetary, crematory or other place) 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State 10-9-99 20d. Method of Disposition (Name of cemetary) 20d. Dotation - City or Town, State 10-9-99 20d. Method of Disposition (Name of cemetary) 20d. Dotation - City or Town, State 10-9-99									
Balt	Departit Departit Imports any inja	21. Signature of Funerel Service Lice	l Home, In		York Rd. on, Md. 21204						
		23a. Part1. Enter the disease, or comshock, or heart tailure. List only	oplications that caused the deeth	Do not enter the mode of dy	ying, such as cardiac	or respiratory arrest,	10#50	Approximate			
P	Physician /Medical Examiner	tmmediate Cause (Final diseasa or condition resulting in death)	CARDIAC ARE	REST DUE TO			ISEAS	Interval Between Onset and Death			
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_6	be asscuted slcian and bunal-transit	Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury	b. ————————————————————————————————————	r as a consequence of):		4		1			
ox 68760,	ficate be physicia is the bur edical	Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or								
B	at the death certify the attending stached for use a Physician/M.	Date of the state				1 00 0111					
0	y the che	Part II. Other significant conditions of	contributing to death but not resu	23b. Did tobacco use contribute to the cause of death?							
T	5 60	RHEUMATOID ART	HRITIS		1 Yes 2 No 3 Probably 4 Unkno						
Records,	requir seen s hould					performed? available pr completion		Were autopsy tindinga available prior to completion of cause of death?			
	The law ate has by page 2 s					1 ☐ Yas		1 ☐ Yes 2 ◯ No			
Vital	iclan: The certificate rector, pag	25. Was case reterred to medical			26. Place of Deat	h (Check only ona))				
>	\$ 00	examinar? 1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3□ DOA C	Xher: 4 Nursing Ho	me 5 Residenca	6 ☐Other (Spe	acity)			
on of	ding Phy h. After this funeral o	27. Manner of Death 1 Naturel 5 Pending	28a. Data of Injury (Month, Day Year)	28b. Time of 28c. Inj		at 28d. Describe how injury occurred ?					
Division	tal or Attending P rs after death. at Director: After t ed in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be detarmined	De One Diese of leive. At he	of Injury - At home, tarm, street, tactory, office			281. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or At within 24 hours after to the Funeral Direct completely filled in by Medical Certifi	29e. Certifier (Check only one) 1 ★ Certifying Pt 2 ★ Medical Example 1	nysician: To the best of my know miner: On the basis of examinati and manner stated.	wledga, death occurred at the ion and/or investigation, in my	time, date and place, opinion, death occurr	and due to the cause(ed at the time, date ar	s) and mannar a nd placa, and du	s stated. e to the cause(s)			
	outh outhin ompl	29b. Signeture and title of certifier	NN N A	29c. Lice	nse number	29d. D	ate signed (Mont	th, Day, Year)			
	F 3 F 0	Joseph J	3 Dunt	M D2398	1:	10	0/5/19				
	19	30. Name and addrass of person who JOSEPH P. GRANT	completed cause of death (Item		. TOWSON	MARYLAN	VD 2120	14			
	State Registrar	31. Date tiled (Month, Day, Year)	32. Registratr's Signat		2007	,	and do ben't	•			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** IRMA ELIZABETH ALBERT BELL 3:45 AM 11, 1999 October 0 /Medical 4s Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore County Holly Hill Manor If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 1□ M 2♥F Yrs. Director 219-16-9221 Usual Rasidence of Decede 94 July 15, 1905 Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 No Towson Directo Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 531 Stevenson Lane USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Maritel Status Bleck, White, etc. 1 ☐ Yas 2 📉 No If Yes, Give Yaar or Datas: 1 Nevar Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White ğ 3 ₩idowed 4 Divorced Completed permit. Pages 1 and 2 should be tilled within 72.1 Department of Health and Mental Hygane. Important if them 27 is marked other than "naturany injury or other traumatic event. 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Giva kind of work done during most of working life. DO NOT use retired) (Specify only highast grada completed) Retail Department Elementary/Secondery (0-12) College (1-4or 5+) 10 th Sales Clerk Store 18. Mothar's Name (First, Middla, Maiden Sumema) 17. Fether's Nama (First, Middla, Last) Be Clara Elizabeth Palm Roman Albert 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Halationship (Type, Print) Judith Ann Kapfhammer (P.O.A.) 7 Orkney Court, Baltimore, Maryland 21212

20a. Method of Disposition

1 Burial 2 Occupation 3 Deamoval from State

20b. Place of Disposition (Name of cemalary, cremetory or other place) 20c. Location - City or Town, Stata 1X Burial 2 Cramation 3 Ramoval from State 4 Donation 5 Other (Specify) 10/13/99 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funaral Sarvice Lightsee 22. Nama and Addrass of Facility Karten auson Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212

Approximate the mode of dying, such as cardiac or respiratory errest.

Approxim 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical tmmediata Causa (Final disaase or condition rasulting in death) weeks Ung Canca Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings svailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1□ Yas 2⊡ No 1 Yas 2 No 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 ☐ Accident

physicien and the buriel-transit Box 68760 The law requires that the deeth certificate be 087 P.O. signed by it Records, s need page 2 certificate Division of Vitai Hospital or Attending Physicien:
 24 hours after death.
 Funerel Director: After this certifical letely filled in by the funeral director. Certification:

the Maryland

72 hours after

Baltimore, Maryland 21215-0020

25a-f show

heme 23s or 25s-f shortiner must be notified at

the Medical Examiner

3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

(Check only one) 29b. Signature and titla of certifier

12 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and dua to tha cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

11. 99

41104

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

Theodore C. Houk, M.D., 7825 York Road, Towson, Maryland 21204

State Registrar

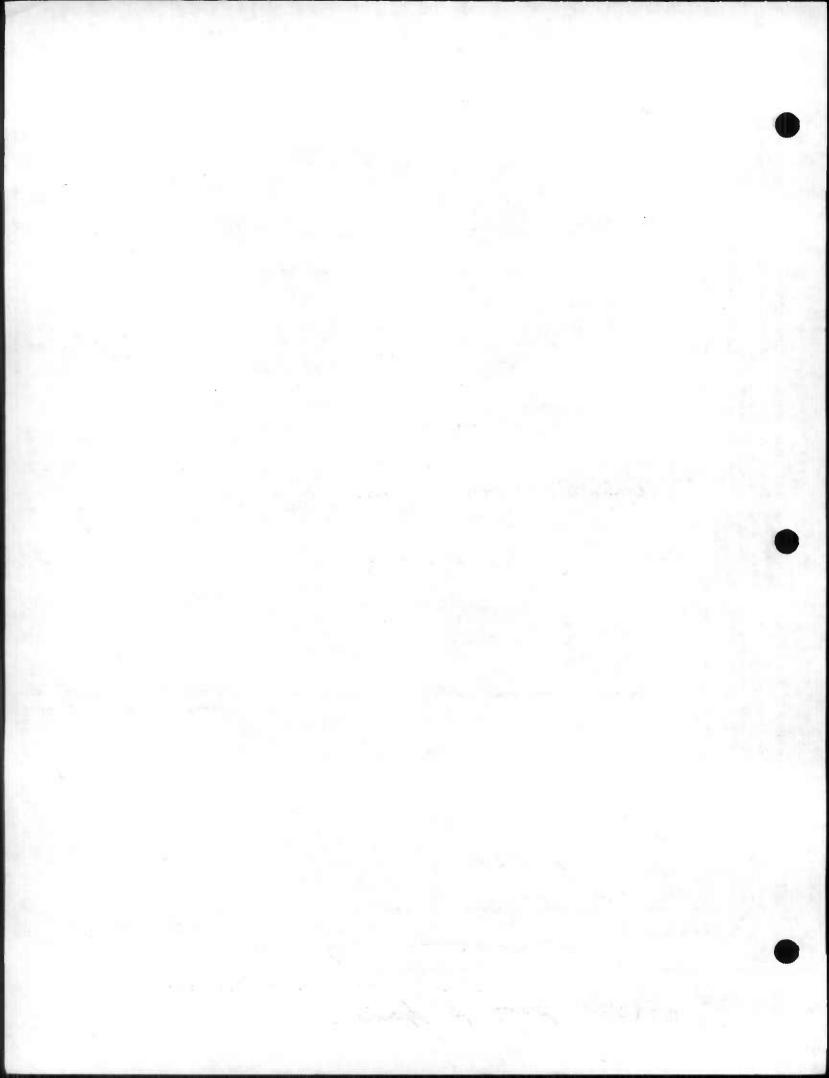
completely

within 2 To the

Medical

29a. Certifier

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death RROWN Month **Physician** -58 PN UST 10 /Medical 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c/County of Death Examiner Hospita more If Under 1 Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) **Funeral** 12 M 20 F Months Days 3 8 Yrs. -21-6148 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23s or 28s4 show any injury or other traumatic avent, the Medical Examiner mass. 10b. County 10c. City, Town or Location 10d. Inside City Limits 12 1es 2 No **Funeral Director** altimor et and Number 10f Zip Code 10g. Citizen of What Country? 728/ 21216 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 1 Never Merried 2 Married Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Yaar or Datas: Be Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 11+4 MIR onstruction 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) illiams 0 Villiam Brown 19a. Informent's Neme/Reletionship (Type, Print) 20b. Place of Disposition (Name of cematery, cremetory or other my 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lrene frucheard 20e. Mathod of Disposition altimo 20c. Location - City of 1 ☐ Buriel 2 ☐ Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Address of Facility Douglass Funeral Service 21. Signature of Funeral Service Line 1701 Mc Culloh Street, Baltsmore, M. J. 21217 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, or shock, or heert feilure. List of Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner tha burial-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated avents resulting in death) Lest Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 88 BSD Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? should be datached 3 Probably Donknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed paga 2 1 Yes 20 No 1 Yes 2 No cartificata or Attanding Physician: funaral director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes No 1 Dinpatient 2 ER/Outpatient 3 DOA Aftar this 28a. Dete of Injury (Month, Dey Year) 27. Mennes of Death 28b. Time of 28d, Describe how injury occurred 28c. Injury at Work? Neturel 5 Pending invastigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 8 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) complately filled in by 4 Homicide To the Hospital 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) end menner steted. (Check only one) 29b. Signature and titla of certifiar 29d. Data signed (Month, Dav. Year) 9

State Registrar 30. Name and address of person who complete

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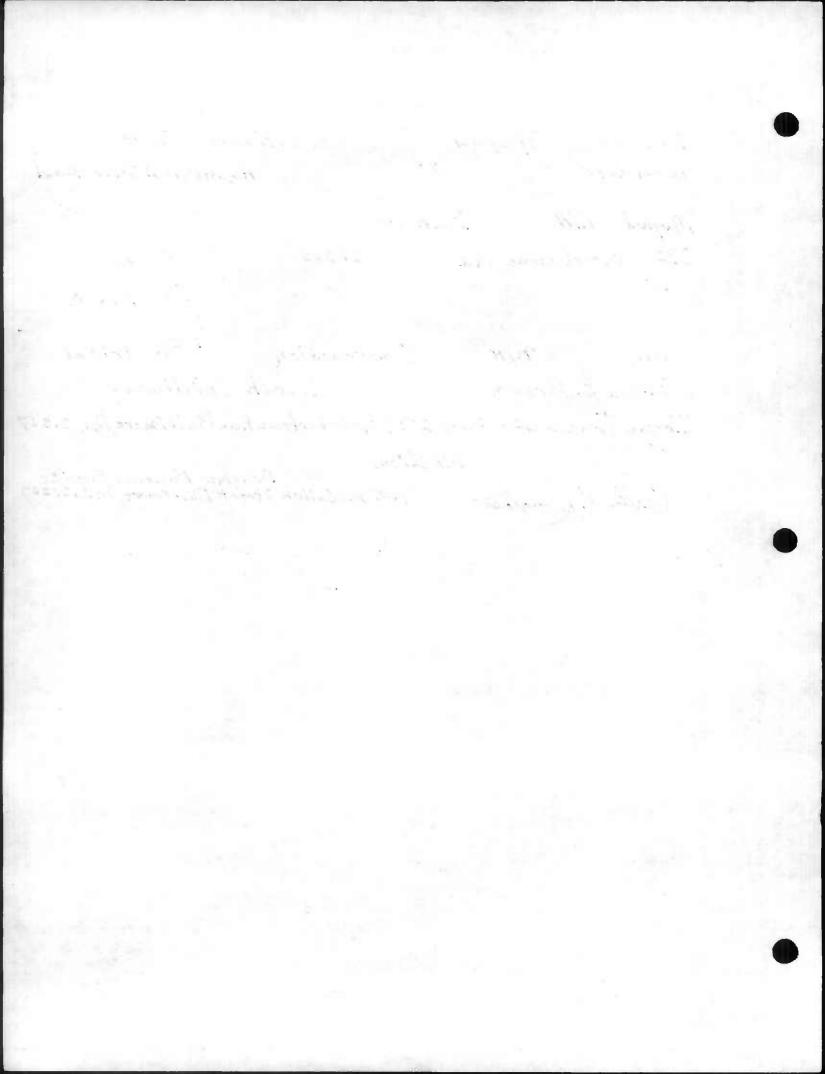
31. Date filed (Month, Day,

DHMH 16 Rev 6/95

ed cause of deeth_(Item 23a) (Type, Print)

2

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
T. 27. 28A-F Certificate of Death
Reg. No. 99-5948-005 AMEND ITEMS: #23 PART Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** ROBERT C. BADDERS OCTOBER 4, 1999 1510 PM /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 623 48th STREET DUNDALK BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days 183 M 2□ F Months Hours 44 10/16/1954 MARYLAND 213-66-5665 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-fahow 1 ☐ Yes 2 ☐ No Director MD BALTIMORE DUNDALK 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 Norma 23a 623 48TH STREET 21224 USA Funeral 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Bleck, White, etc. filed within 72 hours after Hygiene. ther then "natural", or ite 1 2 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Merried "natural", or 1 Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MAINTENANCE Elementery/Secondary (0-12) College (1-4or 5+) HOUSING SUPERVISOR 2YRS HOUSING SUPERVISOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be finent of Health and Mental I ant: If them 27 is marked of WALTER C. BADDERS BEATRICE HURD 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a H ftem 27 is or other train BEATRICE BADDERS (MOTHER) 1913 SWANSEA RD. BALTO., MD. 21239 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete Department of Important: If eny injury or page. GARDENS OF FAITH 10/08/99 4 ☐ Donetion 5 ☐ Other (Specify) BALTO., MD. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21 William Clauste 21212. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Death /Medical Immediate Cause (Finel ACUTE NARCOTIC INTOXICATION diseese or conditio resulting in deeth) Examiner Due to (or es a consequence of) Examiner that the death certificate be executed Due to (or es a consequence of): physician Physician/Medical

Physician

the

signe be

After

death.

after death Director:

To the Hospital of within 24 hours at To the Funeral D completely filled in

Hospital

filled in by

þ

Completed

Be

edical Certification: To

21215-0020

Baitimore, Maryland

Box 68760,

P.O. 1

Records,

Division of Vital or Attending Physician: Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events resulting in death) Last

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t.

23b. Dtd tobacco use contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Nuknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings eveilable prior to completion of cause of death?

1 X Yes 2 No 26. Place of Deeth (Check only one)

Yes 2 No

25. Wes case referred to medical XYes 2□ No 27. Menner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 28b. Time of

Found: M

At home, farm, street, fectory, office

FOUND AT HOME

P 28c. tnjury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

UNKNOWN

Location (Street and Number or Rural Route Number, City or Town, State) 623 48TH STREET DUNDALK,

29a, Certifier

1 Neturel

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated.

**Common Common Com end menner steted.

29b. Signeture and title of certifier

ennis

29c. License number OCME

29d. Date signed (Month, Dey, Year) OCTOBER 5, 1999

uto m

5 Pending investigation

6 Could not be determined

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) hutem

111 Penn Street, Baltimore, Maryland 21201

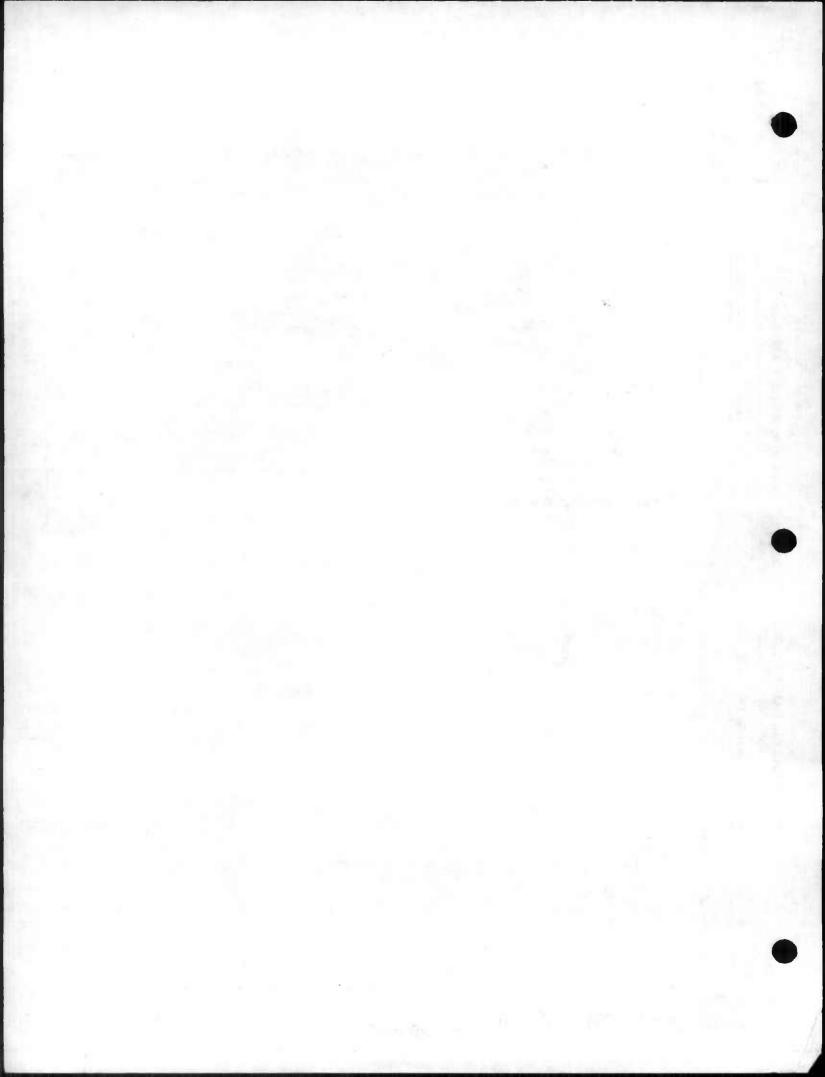
State Registrar

31. Dete filed (Month, Day, Year) 1999

Found:

28e. Pleca of Injury - At horr building, etc. (Specify)

32. Registrer's Signeture Sports



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) OCTOBER 2150 RUSSELL BAKER 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth MEMORIAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stete or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) XX M 2 F Months Yrs. 85 11-10-1913 085-07-0300 MASSACHUSETTS Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. N/A CITY BALTIMORE XIX Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 830 WEST 40th. STREET 21211 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married X X Married 1 ☐ Yes XX No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondary (0-12) BROKER REAL **ESTATE** PLUS 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) LIVINGSTON MARGARITE **IGALLS** RUSSELL BAKER 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 830 WEST 40th. STREET, BALTIMORE, MD., 21211 GRACE A. BAKER (WIFE) 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition XX Burial 2 Cremation 3 Removel from Stete DRUID RIDGE CEMETERY 10-15 PIKESVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility HENRY W. JENKINS AND SONS COMPANY R. A. Kuty 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth CONGESTIVE HEART FAILURE Immediate Cause (Final diseese or condition resulting in deeth) HYPERTENSION Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury DIABETES MELLITUS Due to (or as e consequence of): thet initieted events resulting in deeth) Lest ARTERY DISEASE Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TRACT INTECTION 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 2 PNo 1 ☐ Yes 2 ☑ No 1 Yes 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician/Medical þ

Completed

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Certification:

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funeral

After this

24 hours after death.

within 2

Examiner

Physician

/Medical

Examiner

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Funerai

P

Completed

Funeral

Director

itsm 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Mouical Examinar must be notified at

ò

any injury

Physician

/Medical

Examiner

permit. Peges 1 and 2 should be filed within 72 hours after death Department of Health end Mental Hygiene. Important: If itsm 27 is marked other than "naturat", or Itema 23.

altimore, Maryland 21215-0020

the Maryland

25. Wes cese reterred to medical examiner?

27. Menner of Death 1 Neturel

> 3 ☐ Suicide 4 - Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as steted.

2 Medical Examinar: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

29a. Certifier

29c. License number

29d. Dete signed (Month, Dey, Year) DCTOBER 7,1999

30. Name end address of person who completed gause of death (Item 23e) (Type, Print)

HOSPITAL DR. RAYMOND TAYLOR UNION MEMORIA

State Registrar

31. Dete filed (Month, Dey, Year)



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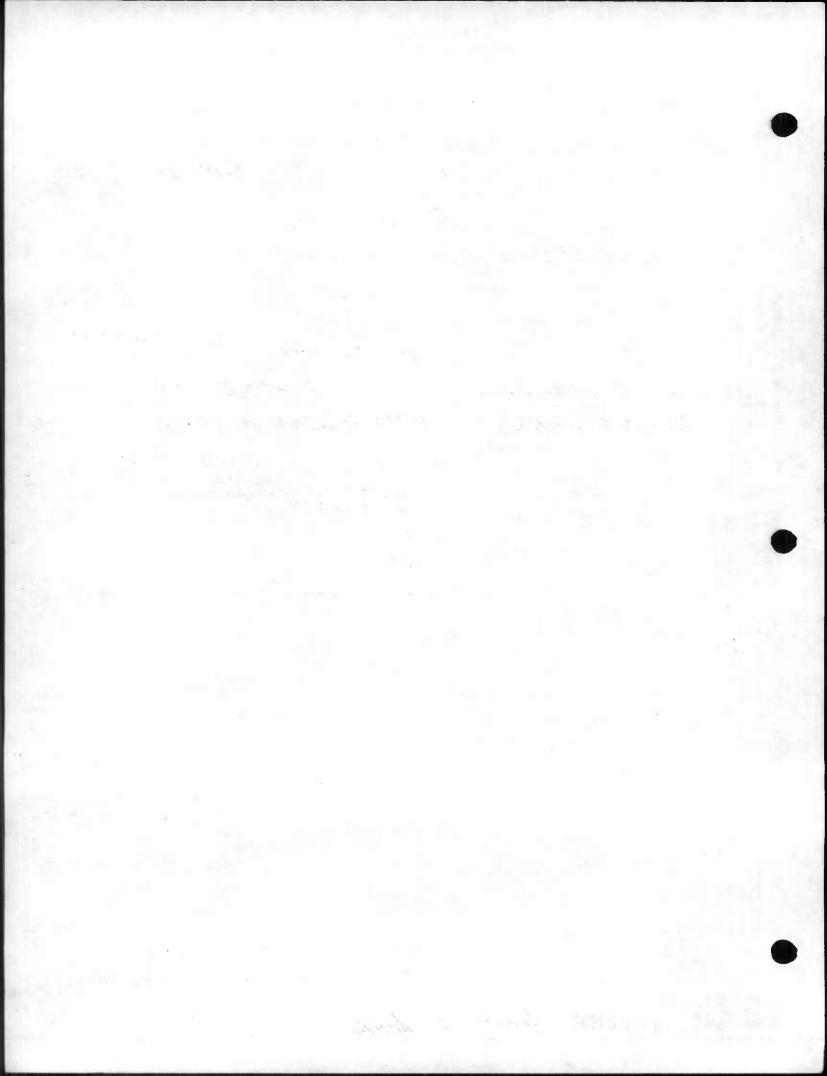
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day Month **Physician** 7:20 P. 4. CCTOBER 0 6,1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PORE 7. Age (In yrs. last birthday) MARIS 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Day, Year) 6 Sex Birthpiace (State or Foreign Country) **Funeral** Days Months 1 M 2 F Hours 231-28-704 Usuel Residence of Decede Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Director MD the 10e. Streat and Numba 10g. Citizen of What Country? 6 Nems 23s Funeral 11. Maritel Stetus 12. Wes Decedent Ever in U.S. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yas 2 No
If Yes, Give
Year or Detes: 1 Nevar Merried 2 Married Saltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify à 3- Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. RUNING permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if frem 27 is marked other than any injury or other traument. Elementery/Secondary (0-12) College (1-4or 5+) 40USEWI 17. Fathar's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) OONE 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ELMA 9N/LUZERNE 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Suriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Nama and Addrass of Fecility How ELL FUNERAL ROME 4600 LIBERTY Heights AVE, BAZTO 11804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physiclan** /Medical Immedieta Cause (Finel diseese or condition resulting In deeth) Examiner Due to (or as a consequ Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 3 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was en autopsy performed? Completed Hent 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical axaminer?

1 Yes 2 No Maris at Mercy 26. Place of Death (Check only one) Stella Be Hospitel: 20 No Other: 4 Nursing Home 5 Residence Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menurer of Deeth 28d. Describe how injury occurred 28a. Dete of tnjury (Month, Day Year) 28h Time of 28c. Injury et Work? 5 Pending investigation Neturet To the Hospital or Attending within 24 hours after death.

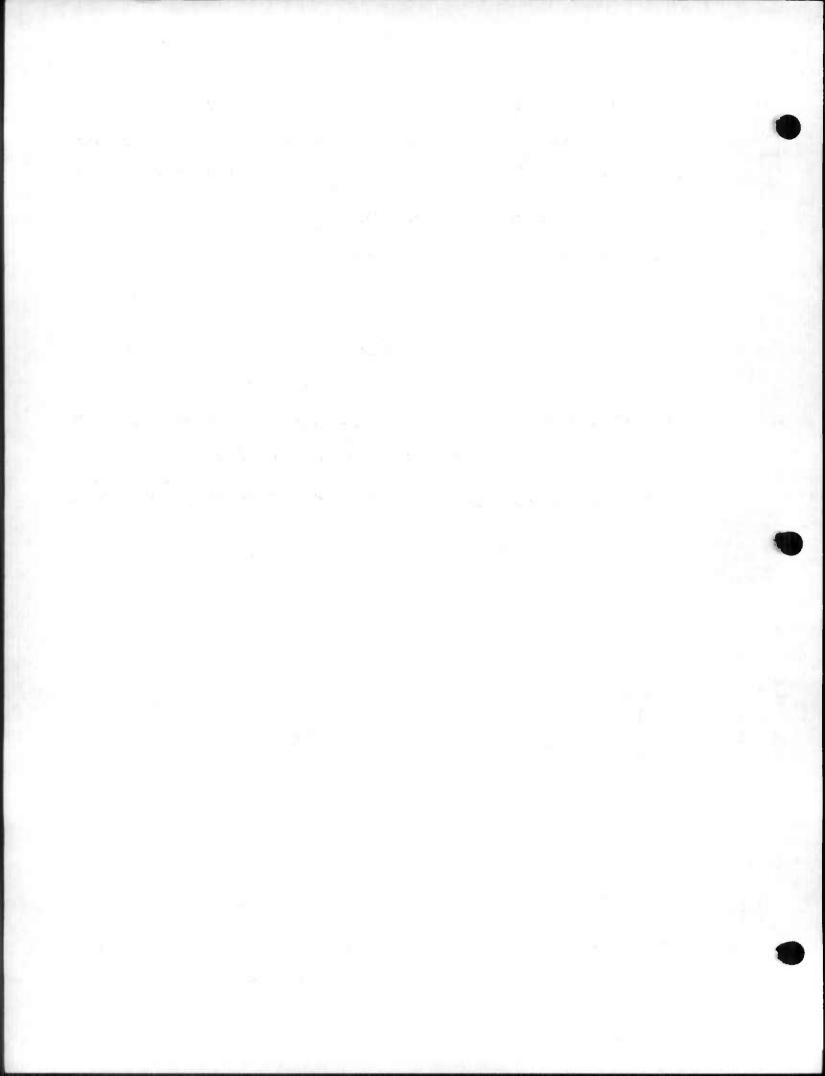
To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not ba 3 Suicida 281. Location (Street end Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred et the time, date and piace, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certific 29c. License number 29d. Date signed (Month, Day, Year) 21 MO D40854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21202 Bultinone St Paul Kuscher 301 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar oosts

A DHA



State of Maryland / Department of Health and Mental Hygiene 99 3 | 664

					C	ertificate	e of L	Death	F	leg. No.	31004	
			1. Decedent's Name (First, Middle, Last,						2. Date of Dea	th	3. Time of Death	
	Physici /Medic		indigated D. Diooks							er 10, 1	999 1:30 pm	
	Examir		4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or L									
			712 Crosby	Road			1	Catonsv	ille		Baltimore	
	Funeral Director		213-03-3833	7. Age (In ya	s. last birthda Yrs.	Months	1 Yaar Days	If Undar 24 Hrs Hours Min		1915	9. Birthplace (State or Foreign Country) Maryland	
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or	Location					10d. inside City Limits	
	Sa-f aho	Director	MD Balt:	imore		nsvill					1 ☐ Yes 2 ☑ No	
:	1 5 5 5 T	Die	10e. Street and Number 10f. Zip Code							0g. Citizan of WI	hat Country?	
	ath w	a	712 Crosby Road 21228							U.S.A.		
Maryland 21215-0020	filed within 72 hours after death with the Maryland Hydione. friet than "natural", or items 23e or 28e-f ahow int, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yes 2 ૐNo If Yes, Give Year or Dates:	U,S. 1	3. Was Deced If Yes, spec			Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc. White	
2-0	72 ho	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. De	cedent's Usua	I Occupa	ation	ndrina	16b. Kind of Bus	iness/industry	
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2	d 2 should the end Menion 7 farmarket traumatic	To	19a. Informant's Name/Relationship (Ty	me Drint)	10h M	niling Address	(Ctroot o				Made Tin Code 1	
<u>8</u>	0 0 0		Carol Frey (Daught			_			urt. Mt.			
<u>ق</u>	Health Health Jem 27		20a. Method of Disposition	20b.		sposition (Nameremetory or or			Date Date		City or Town, Stata	
	permit. Peges 1 end Department of Health Important: If item 27 any injury or other to ODCS.		1 Ø Burlal 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Me	eadowr:	idge Me	emor:	ial Park		Elkridg	ge, Maryland	
n n	permit. Peg Department Important: I any fnjury o		21. Signature of Funeral Servica License	Lemmer	,	22. Name and 1630 Ed	d Addres dmon	s of Facility Widson Ave	tzke Fun enue, Cat	eral Hon onsville	nes, Inc. e, MD 21228	
			23a. Part1. Entar tha disease, or complishock, or heart failure. List only or	ications that causad the de-	ath. Do not e	enter the mode	e of dying	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between	
7	Physician /Medical Examiner	ı	Immadiata Cause (Final disease or condition resulting in death)	a Alta	(or as e cons	sequence of):		Dene	tia		Onset and Death	
	led lsit	Examiner	_ t	5								
	s end	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Dua to	(or es a cons	sequence of):						
3	icete be executed physician end s the buriel-trensit		cause. Enter Underlying Ceuse (Disease or injury that initieted events	0.								
68760,	ng phy es the	Medical	resulting in death) Last	Dua to (or as e cons	sequenca of):						
Rox	eath cer ettendir for use			1								
	dea he ett ed fo	sici	Part ii. Other algnificant conditions con	ntributing to death but not re	sulting In the	underiying ca	ause give	en in Part I.	23b. Did to	obacco use cont	ribute to the cause of death?	
7.	that the de ned by the e deteched t	by Physician/	Anemia						1□ Y	08 2 No	3 Probably 4 Unknow	
Scoras	aw requires that the death certificete be executed is been signed by the ettending physician end 2 should be deteched for use as the buriel-trensit	Completed b	CVA -	Cesepio	vesta	ler	~ < <	cident	24a. Was a perfor		24b. Were autopsy findings available prior to completion of causa of deeth?	
- E	ine law ate has b page 2 s	E O	L'a free	tures					1□ Y	es 2BNo	1 ☐ Yas 2 ☐ No	
- 6				, , ,				28. Plece of De	ath (Check only or	7e)		
Ital			25. Was case referred to medical	examiner/ Hospital: Other:					Homa 5 ☐ Rasidance 6 ☐ Othar (Specify)			
Vital P	ysician: Is certifica director,	Be	examiner?	Hospital: 1 Inpatient 2[☐ ER/Outpat	HeIII 3LI DO						
	rnysician: rthis certifica	To Be	examiner? 1 Yes 2 Ho F 27. Manner of Deeth 1 Waturel 5 Pending	1 ∐ inpatient 2L	28b. Time	e of 2		at ?	1	ow injury occurre		
UNISION	enoing Pnysician: eath. or: After this certifica the funeral director,	ertification: To Be	examiner? 1 Yes 2 No F	1 ∐ inpatient 2L	28b. Time Injury	of 2	10		28d. Describe h	ow injury occurre		
DIVISION	nospital or arending Priysician: 4 hours after death. Funeral Director: After this certified tely filled in by the funeral director,	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Notice 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 Certifying Physical P	28e. Date of Injury (Month, Dey Year) 28e. Piace of Injury - At	28b. Time Injury home, farm, ify)	of y M street, factory	1 🔲 ` , offica at the tim	rat (? Yes 2 □ No ne, dete and plec	28d. Describe h 28f. Location (S City or Tow	ow injury occurre treet end Numbe n, Stete) euse(s) end men	r or Rural Route Number,	
DIVISION	nospital or arending Priysician: 4 hours after death. Funeral Director: After this certified tely filled in by the funeral director,	ertification: To Be	examiner? 1 Yes 2 No F 27. Manner of Deeth 1 Masturel 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examin	28e. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specialization)	28b. Time Injury home, farm, ify)	street, factory eth occurred a investigation,	1 [] \ r, offica at the tim in my op	rat (? Yes 2 □ No ne, dete and plec	28f. Location (S City or Tow e, end due to the curred et the time, c	ow injury occurre treet and Numbe n, State) euse(s) and man late and placa, er	r or Rural Route Number,	
Division of Vita	oing Physician: h. After this certifica funeral director,	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Notaturel 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examination)	28e. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specialization)	28b. Time Injury home, farm, ify)	street, factory street occurred a investigation,	offica at the tim in my op License	reat Yes 2 No No No No No No No No No No	28f. Location (S City or Tow e, end due to the curred et the time, c	treet end Numbern, Stete) euse(s) end men late end placa, et	or or Rural Route Number, ner as steted. Indidue to the cause(s) (Month, Day, Yaar)	
DIVISION	nospital or arending Priysician: 4 hours after death. Funeral Director: After this certified tely filled in by the funeral director,	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Deeth 1 Notaturel 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examination)	28e. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specialization) sician: To the best of my knoer: On the basis of examinend manner stated.	28b. Time Injury	street, factory street occurred a investigation,	offica at the tim in my op License	reat Yes 2 No No No No No No No No No No	28f. Location (S City or Tow e, end due to the curred et the time, c	treet end Numbern, Stete) euse(s) end men late end placa, et	or or Rural Route Number, ner as steted. nd due to the cause(s) (Month, Day, Yaar)	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Physician Bockmiller 0940 Robert ib October 1999 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Maryland University If Under 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1☑M 2□F 212-36-1584 62 Director Jan 9, 1937 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ☐ Yes 2 No MD **Baltimore** Director Catonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 421 Chalfonte Drive 21228 U.S.A. "natural", or thems 23a Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 GYes 2 No 1956-62 If Yes, Give Yeer or Detes: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after Hygiene. Ither than "natural", or the 1 Never Merried 2 Merried White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Analyst Social Security Admin permit. Pages 1 and 2 should be filled.
Department of Health and Mental Hygii fingoritant. If then 27 is marked other any injury or other traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Richard B. Bockmiller Hilda C. Coar 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Barbara Z. Bockmiller, Wife 421 Chalfonte Drive, Catonsville, MD 21228 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlet 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) John's Cemetery 10/13/99 Ellicott City, MD 21. Signature of Fungral Service Licensee 22. Name end Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or haart failure. List only one cause on each lina. Approximete tntervel Between Onset end Deeth **Physician** /Medical Immediata Causa (Final Primary Sclerosing disease or condition resulting in death) Examiner Examiner ande da ettending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as e consequence of): Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? VE Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

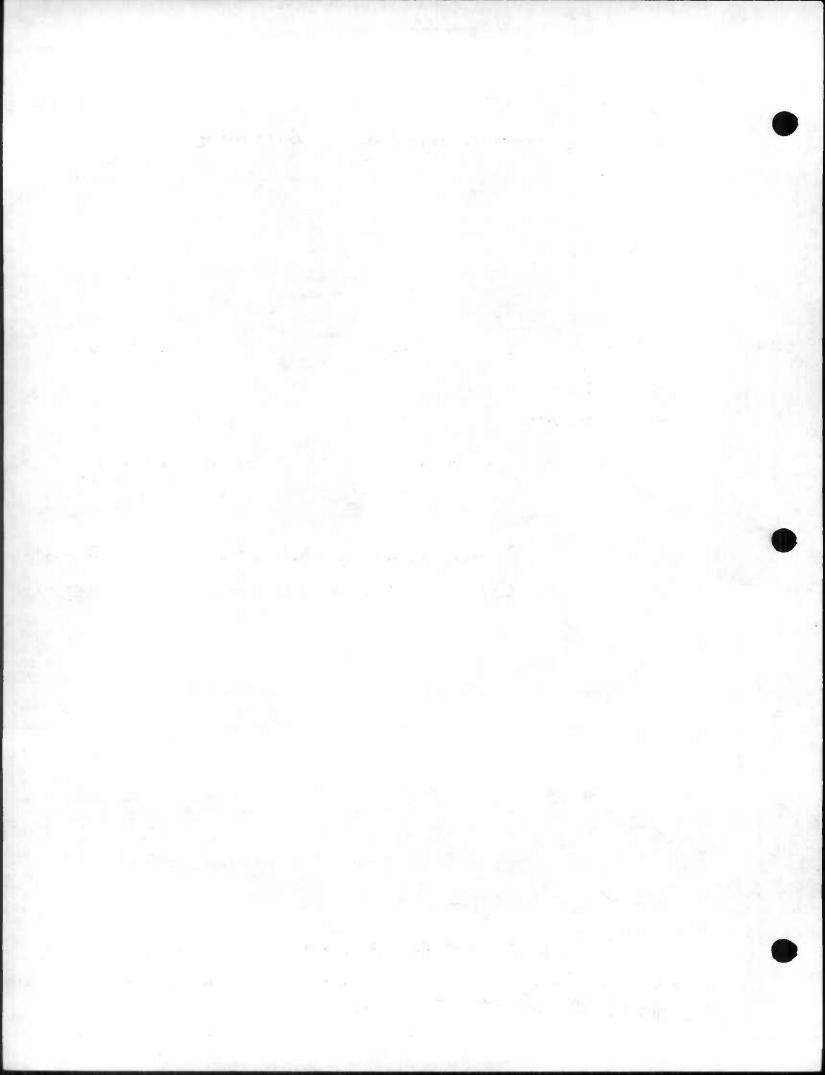
To the Funeral Director: After this certifical completely filled in by the funeral director, I Be 25. Wes case raferred to medical 26. Placa of Death (Check only ona) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manger of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner as a stated. 29a. Certifier (Check only one) 29b. Signature, and title of certif 29c. License number 29d. Dete signed (Month, Day, Year) Resident Ostober 10, 1989 26 1143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reid 2 9 Sou Baltomore, Mary land 21201 Street Maurica leene

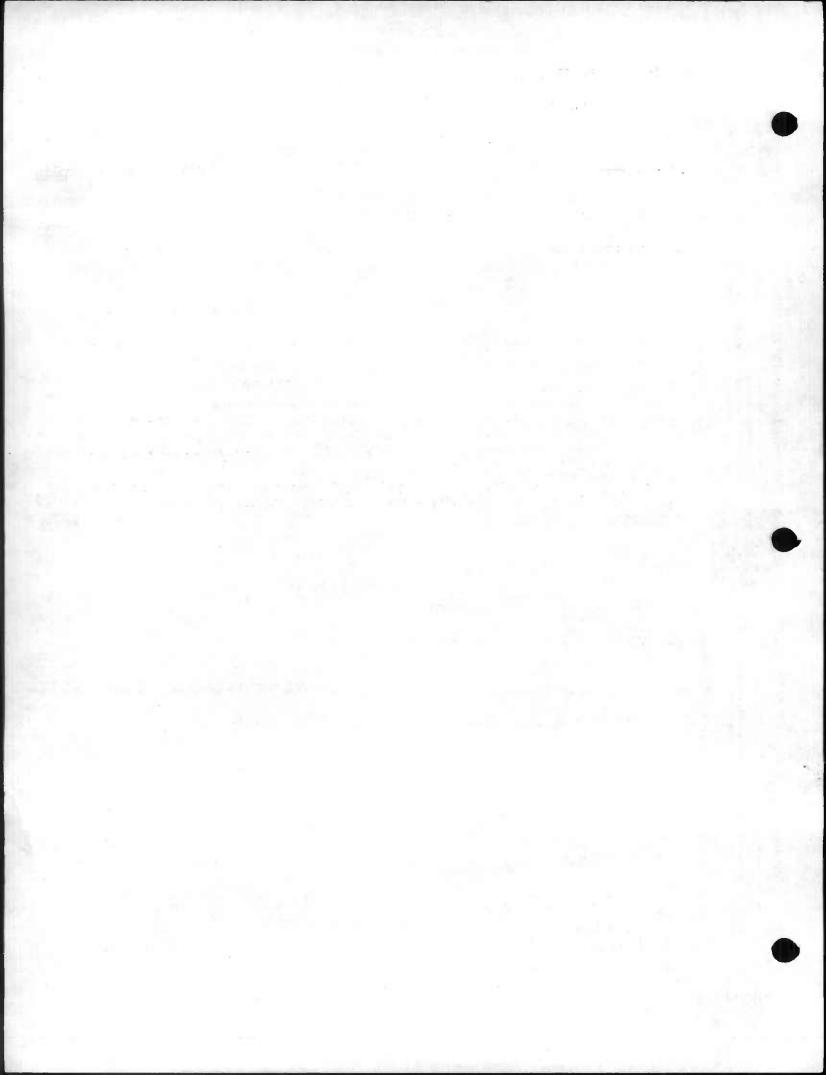
DHMH 16 Rev 6/95

State Registrar OCT 12 1999

32. Registrar's Sign



Ame	ended Item#5 perFH G776			tificate of		i wentai rij	Reg. No.	9 31666		
Physician	1. Decedent's Name (First, Middle, Last, ANDREW		A.I			2. Date of D Month	Day	Year 1999 11: 50 P.Y		
/Medical Examiner	4a Fecility Name (If not institution, give	street and number)				OCTOP or Location of Dea	th 4c. County	of Death		
	HARBOR HOS 5. Social Security Number 6. Sec	× 7. Age (In yrs. I		If Under 1 Year		IS. 8. Date of B		9. Birthplace (State or Foreign		
uneral rector	248-18- 3138 3183	M 2□F 86	Yrs.	Months Days	Hours M	in. 8. Date of Bi	ay, Year) 1912	9. Birthpiace (State or Foreig Country) South Carolina		
Mon W	Usual Residence of Decedent 10e. State 10b. County	10c. City	y, Town or Loc	ation				10d. Inside City Limit		
be notified be notified Director	Maryland N/A	Bal	timore	·				1 X Yes 2 □ N		
at be or a	10e. Street and Number 600 Roundview Road	i		10f. Zip Code 212	25		10g. Citizen of W			
al, or tems 23a or 28s-f show Laminer must be notified at by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		las Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	Blac	e - American Indian, kk, White, etc. - Black		
n, tre Wedge En.	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give k	ent's Usual Occup ind of work done O NOT use ratire Equipme	during most of v d)			ruction		
e ve	8th 17. Father's Name (First, Middle, Last)		-		18. Mother's N	lama (First, Middle Bell Sm		a)		
is marke raumatic	Andrew Brown, Sr. 19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street		Rural Route Numi		Stata, Zip Code)		
n 27 is ser tra	Brenda Brown/Daugh				Road,	· · · · · · · · · · · · · · · · · · ·		and 21225		
important: if item 27 is marke any injury or other traumatic once.	20a. Method of Disposition 1 Burial 2 Cremation 3 S 4 Donation 5 Other (Specify)	Removal from State		ition (Name of atory or other place 1 Cemete		Date 10/9/99		city or Town, State n, Maryland		
any inju	21. Signature a Funeral Service Licensee 22. Name and Address of Facility William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryla									
sician edical	23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death ne causa on each line.				liac or respiretory	errest,	Approximata Interval Between Onset and Death		
miner	resulting in death) Due to (or as a consequence of):									
in end hel-transit Examiner	Sequentially list conditions,	0	r as a consequ		0N					
physician and s the buriel-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated evants resulting in death) Last	Due to (or	as a consequ	ence of):						
d by the attending pt atached for use est Physician/Med	L.	1.						1		
the attended for hed for	Part II. Other significant conditions con	ntributing to death but not resu	23b. Dtd	23b. Dtd tobacco use contribute to the cause of dec						
igned by the be datached by Physic	SEPSIS 10 Yes 2 Xino 30									
2 should				-11			s an autopsy formed?	24b. Were autopsy finding available prior to completion of cause of death?		
						1 🗆	Yes 2 No	1 ☐ Yes 2 ☒ No		
l director	25. Was case referred to medical examiner? 1 Yas 2 No	lospital:	ER/Outpatient	3 DOA Oth	MAC.	Death (Check only Home 5 Res		er (Specify)		
	27. Mannar of Death 1 Matural 5 Pending 2 Accident investigation	28a. Data of Injury (Month, Day Year)	28b. Time of tnjury	28c. Injur Wor M 1		1	tome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
al Director: After to din by the funeral Certification:	3 Suicide 6 Could not be 4 Homicide datamined	28e. Place of Injury - At homa, farm, street, factory, office 28f. Loc					(Street and Numb own, State)	er or Rural Route Number,		
To the Funeral I completely filled Medical Ce		stcian: To the best of my knowner: On the basis of examinat and manner stated.								
To the	29b. Signature and title of certifier	P942		29c. Licens				d (Month, Day, Year)		
1	hilear				3132		OCTOBE	R 05, 1999		
/	30. Name and address of person who co SRIKANTH RAMA		23a) (Type, P	HARBO	R HO	SPITAL	CENT	ER.		
State	31. Date filed (Month Pry. 102) 199	22 Pagletear's Signat	ture /	Long	1					



The law requires that the death certificate be axecuted P.O. Box 68760. Records, Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funerel Director: After this certifical eleisy filled in by the funeral director, 1

- Phow

filed within 72 hours after Hygiene.

altimore, Maryland 21215-0020

Certification: To 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signatura and titla of certifier

Registrar

To the Hosp within 24 hor To the Fune completely fi

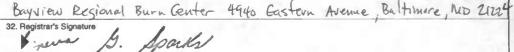
31. Data filed (Month, Day, Year) OCT 12 1999

Lauzon

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

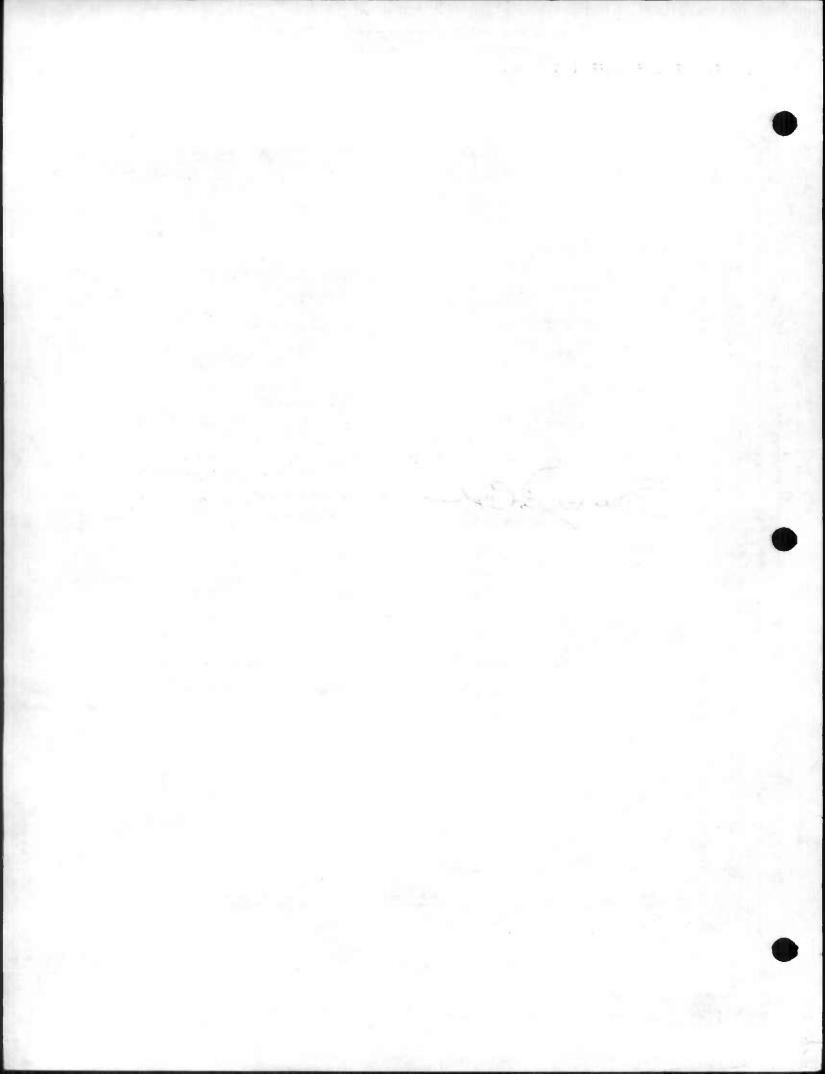
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Steven



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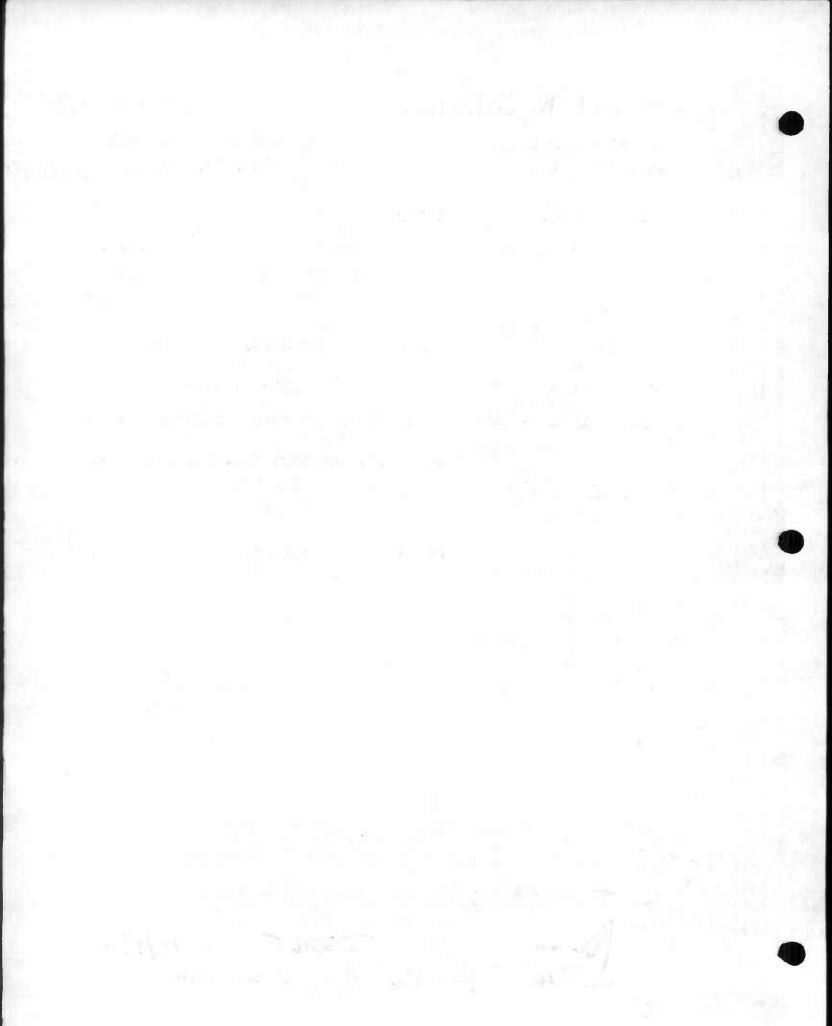
October



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** /Medical 4a. Fecility Neme (If not institution, giva straet and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner | Manchester | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min ct (Month) (Pay. Long View Nursing Home Carroll 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthpteca (Steta or Foreign Country) **Funeral** X□M 2□F 83 213-14-4762 Yrs Director Summerville, Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, tra Medical Examiner must be notified at Director Md. Carroll Millers 1 Yas 2 No 10e. Straet and Number 10f. Zin Code 10g. Citizen of What Country? 21102 U.S.A. 4215 Grave Run Road death Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decadent Ever in U,S. Armed Forcas? 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiena. Important: if them 27 is marked other than "natural", or iten any injury or other traumatic avent, the Mental Force. Black, Whita, etc. 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Tool Black & Decker Corp. 17. Fether's Nema (First, Middle, Lest) 18. Mothar's Name (First, Middle, Malden Sumema) Be Emily Wagoner James Calhoun 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rosa Lee Calhoun - wife 4215 Grave Run Road Millers, Md. 21102 20b. Ptece of Disposition (Neme of cemetary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Steta Date Buriai 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Millers U.M. Cemetery Oct. 11, 1999 Millers, Md. 21. Signature of Funerei Service Licensee 22. Neme end Address of Facility Eckhardt Funeral Chapel water MODER 3296 Charmil Dr. Md. 21102 Manchester. Part Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, or heert failure. List only one ceuse on each line. Approximeta tntervei Between Onsat end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of) Examiner The law requiras that the death certificate be executed physician and s the burial-trans Sequentielly tist conditions, if eny, leeding to Immadiete cause. Enter Underlying Cause (Diseese or trijury that initieted events resulting in deeth) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): attending p for usa as as signed by the a d be datached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings 24a. Wes en eutopsy performed? eveilebla prior to completion of cause of deeth? page 2 has 2 NO 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifice 25. Wes case referred to medicat examiner? Be 28. Plece of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how trijury occurred 5 Pending investigation Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in 1d Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end plece, and dua to tha causa(s) end manner es steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and menner stated. 29a. Certifiar Medical completely (Check only one) within 2 29b. Signature and title bt certifier 29c. License number 29d. Date signed (Month, Dey, Year) 33165 16 99 41.75 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 32 Berghiller's Symulure 7 m 6

State Registrar



DHMH 16 Rev 6/95

State

Registrar

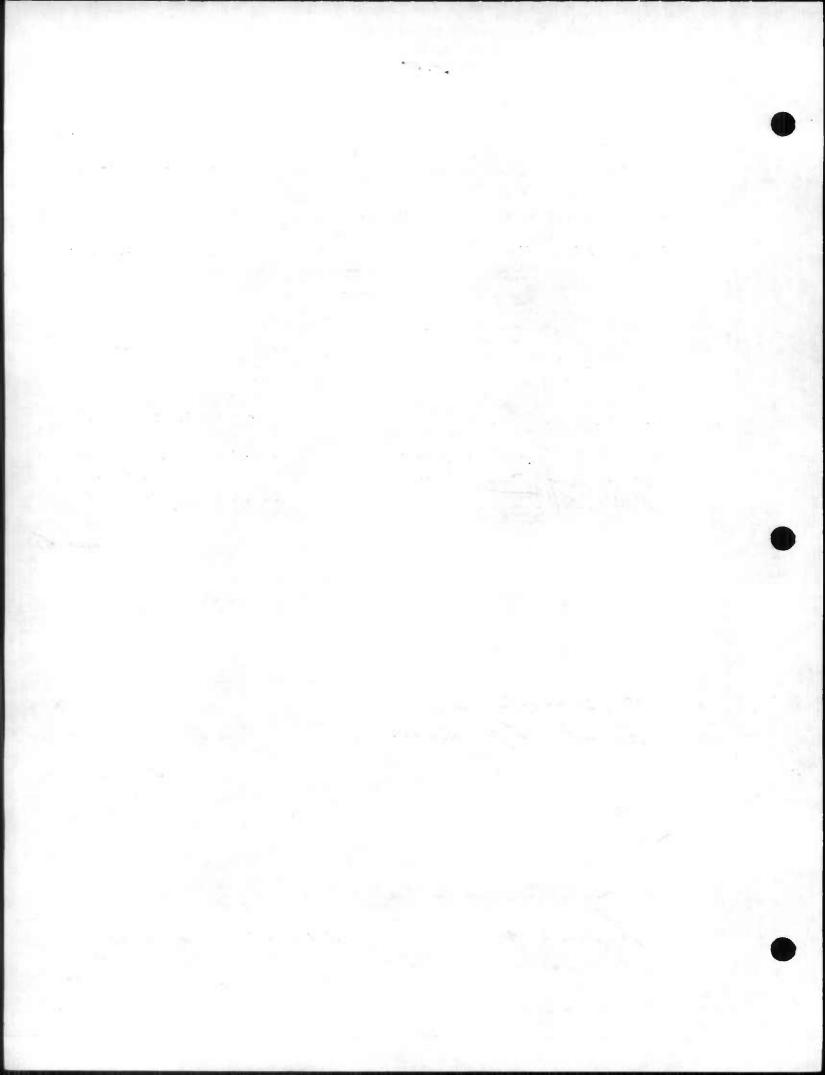
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32. Registrar's Signeture



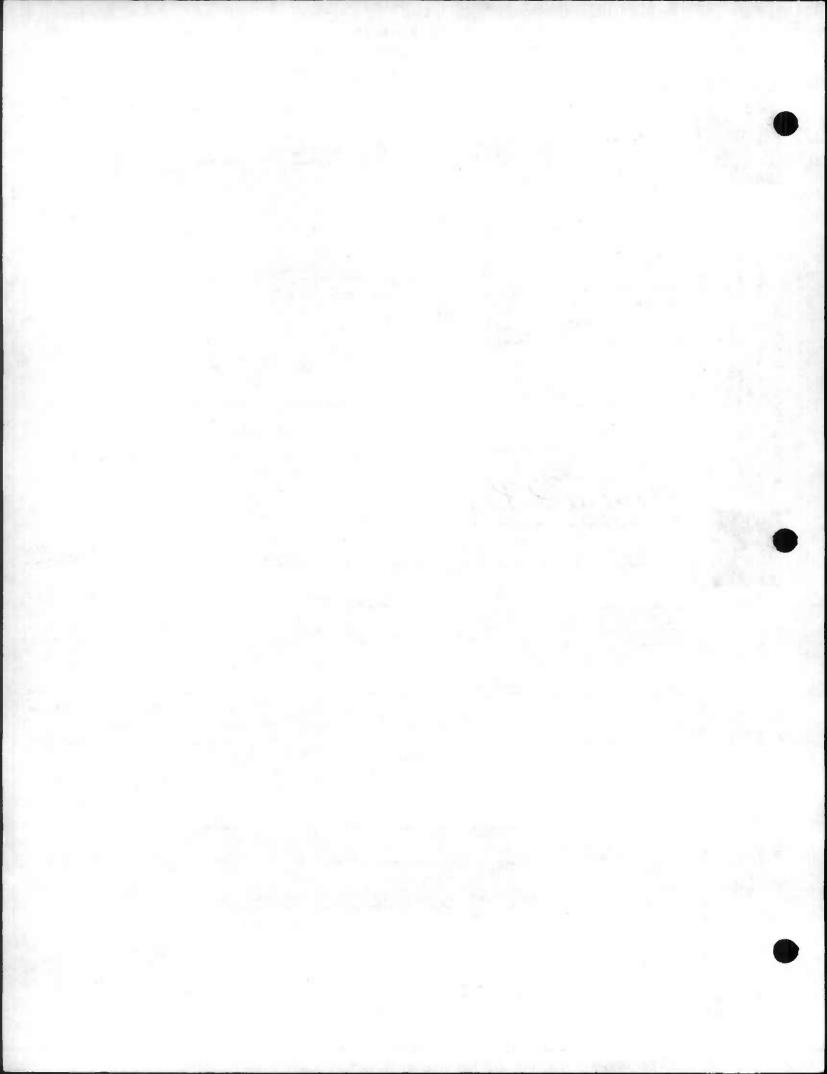
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 10:14pm Ewald G. Ciolek October 8 1999 /Medical 4a Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1242 Queen Anne Avenue Odenton Anne Arundel If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 19,1932 Birthplace (State or Foreign Country) **Funeral** Days M 2□ F Months Hours 67 081-32-7867 Poland Director Usual Residence of Decedent with the Maryland r 28a-f ahow 10c. City. Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 Yes 2 No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tam 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Examinar must be a 1242 Queen Anne Avenue 21113 USA Nema 23a death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiens. Important: if Itam 27 is marked other than "natural", or item any Injury or other traumatic event, the Hedical Experience once. tyCYes 2□ No If Yes, Give Year or Dates: 1953-83 1 ☐ Never Merried 2 X Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Sergeant US Army 4 12 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Paul Ciolek Maria Grushka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Barbara Ciolek (Wife) 1242 Queen Anne Avenue, Odenton, MD 21113 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from State Arlington National Cem. 10/19 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Hardesty Funeral Home, P.A. ulla 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · Metactate Cascenoma Examiner Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 QUnknown Division of Vital Records, by Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has **958d** 1 Yes 2 No 1 Yes 2 No certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cartification of the funeral director; it 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier end manner stated. 29b. Signature and title of portifier 29c. License number 29d. Date signed (Month, Dey, Year) WD cause of death (Item 23a) (Type, Print) Road # 106 oder ton 1413 Annapoly Registrac's Signature 2/1999

DHMH 16 Rev 6/95

Registrar

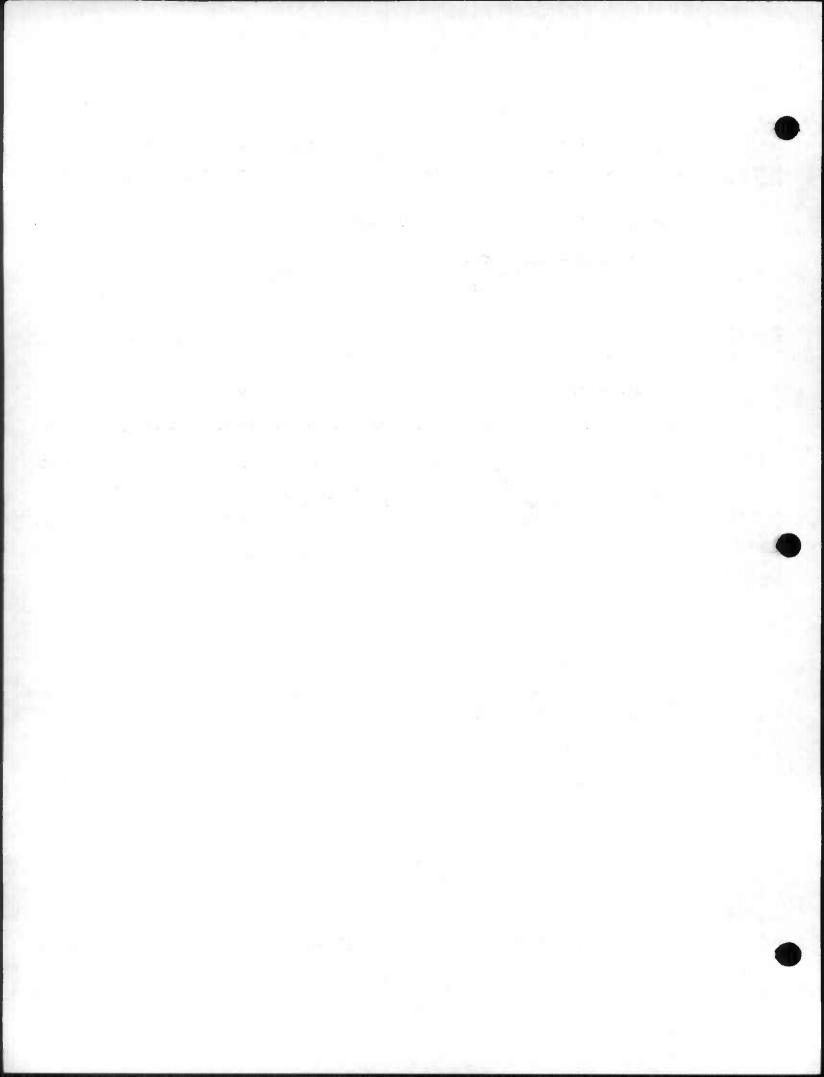


State of Maryland / Department of Health and Mental Hygiene 9 9

						ertificate of		F	Reg. No.	7 0	010/1
	Physic	ian	Decedent's Name (First, Midd	and the same of	JR			2. Date of Dee Month	Day	Yeer	3. Time of Deeth
	/Medi		WILLIAM	W. CANN			OCT		99	4:03 pm	
	Exami	ner	4e. Facility Neme (If not institution		")		4b. Cify, Town, or Lo			of Deeth	
_			FUTURE CARE 5. Sociel Security Number		ge (In yrs. last birthdi	lf Under 1 Year	BALTIMORE If Under 24 Hrs.		N/A	0.014	
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	Department of Important: If I any injury or otice.		21. Signature of Funeral Service	Licenseo /		22. Name end Addre		AMITALTONIA			
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	S 5	70	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outpe	ient 3 DOA Oth	ner: 4 Nursing Hor	ne 5 Resid	enca 6 Oth	er (Specify	y)
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	ai or Atten s after deet if Director: ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rure) R								Route Number,
	To the Mospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier 1 ☐ Certifylr 2 ☐ Medical	g Physician: To the best Examiner: On the basis of end manner s	of examination end/or	ath occurred at the tir Investigation, in my o	me, date end piece, e plnion, death occurre	end due to the co	cause(s) end me date and place,	enner es st end due to	lated. the ceuse(s)
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Y	Sta	te	31. Dete filed (Month, Day, Kear)		rar's Signature	1		0		~	21234

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 6.40 03,1999 4b. City, Town, or Location of Death oshva 4a Facility Name (If not institution, give street and number) 4c. County of Death Aques Healthcare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) 50X 10X M 2□ F Yrs. Vly 08,1999 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21144 925 ruel DVI 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 2 No 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Son Unknown Ta 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Agnes 900 MD 21229 Healthcare Caton Humore 20b. Place of Disposition (Neme of cametery, cremetory or other place, Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State Aques Healthcare 10 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stagnes Healthcare Goo Caton Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) 589 Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) eme remat Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 0 Denia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

Examiner ettending physicien end for use es the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical signed by t Completed certificate hes b lirector, page 2 s Hospital or Attending Physician: director. Be To After this funeral Certification:

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Physician /Medical

Examiner

Physician

/Medical

Examiner

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Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hyglene. Important: If fens 27 is marked other than "natural", or ferms 23e or 28e-f ahow any Injury or other traumatic event, the Medical Eventue must be notified as

altimore, Maryland 21215-0020

25. Was case referred to medicel examiner? 1 Yes 2 No 27. Manner of Deeth 1 Netural 2 Accident 3 Sulcide

4 Homicide

(Check only one)

30. Name and add

29a. Certifier

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Dey Year)

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

MYSICHAN ess of person who completed cause of deeth (Item 23a) (Type, Print)

SANTOS

29d. Dete signed (Month, Dey, Year)

31. Date filed (Month, Dey, Year)

32. Registrer's Signature

Agnes Health Care Balto 21229

State Registrar

DHMH 16 Ray 6/95

within 24 hours efter death. To the Funeral Director: At

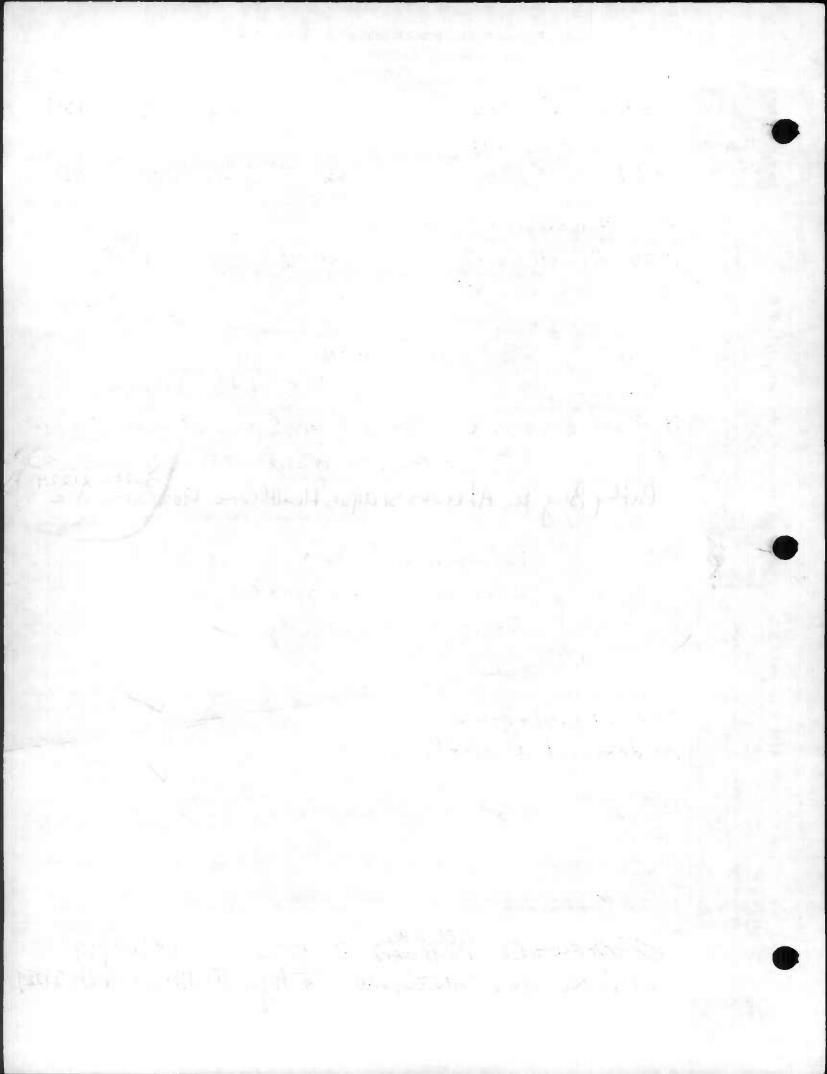
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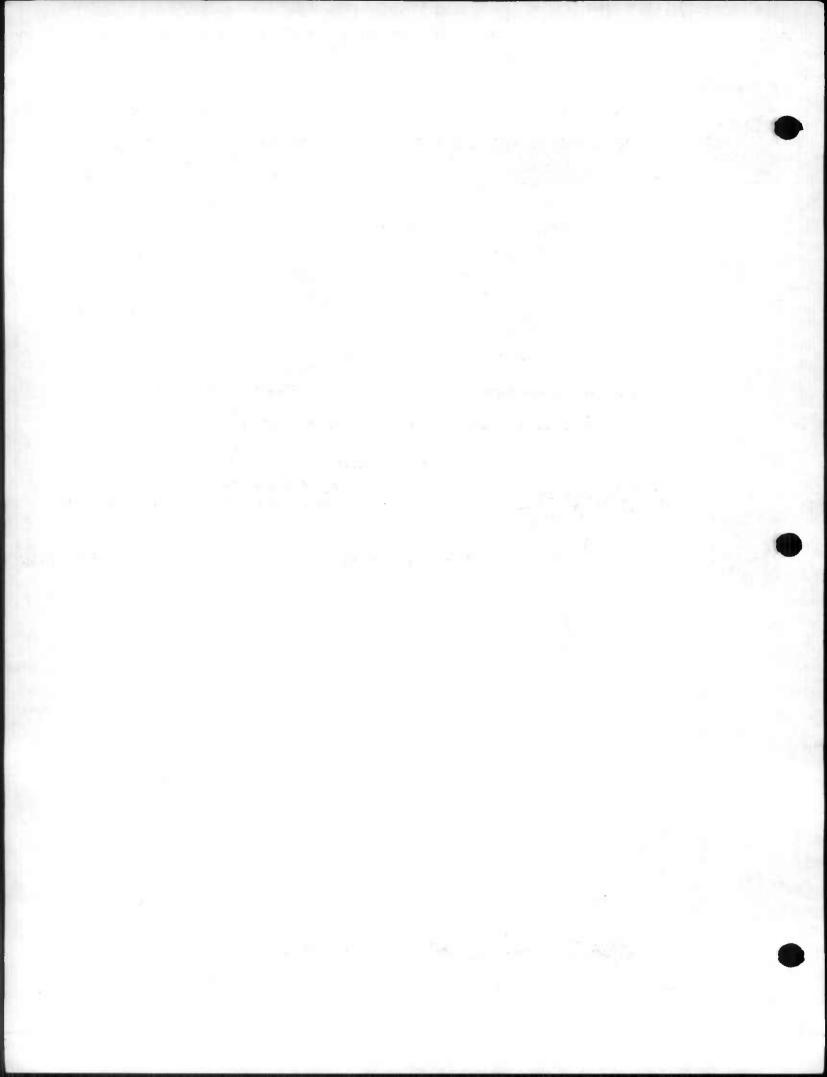
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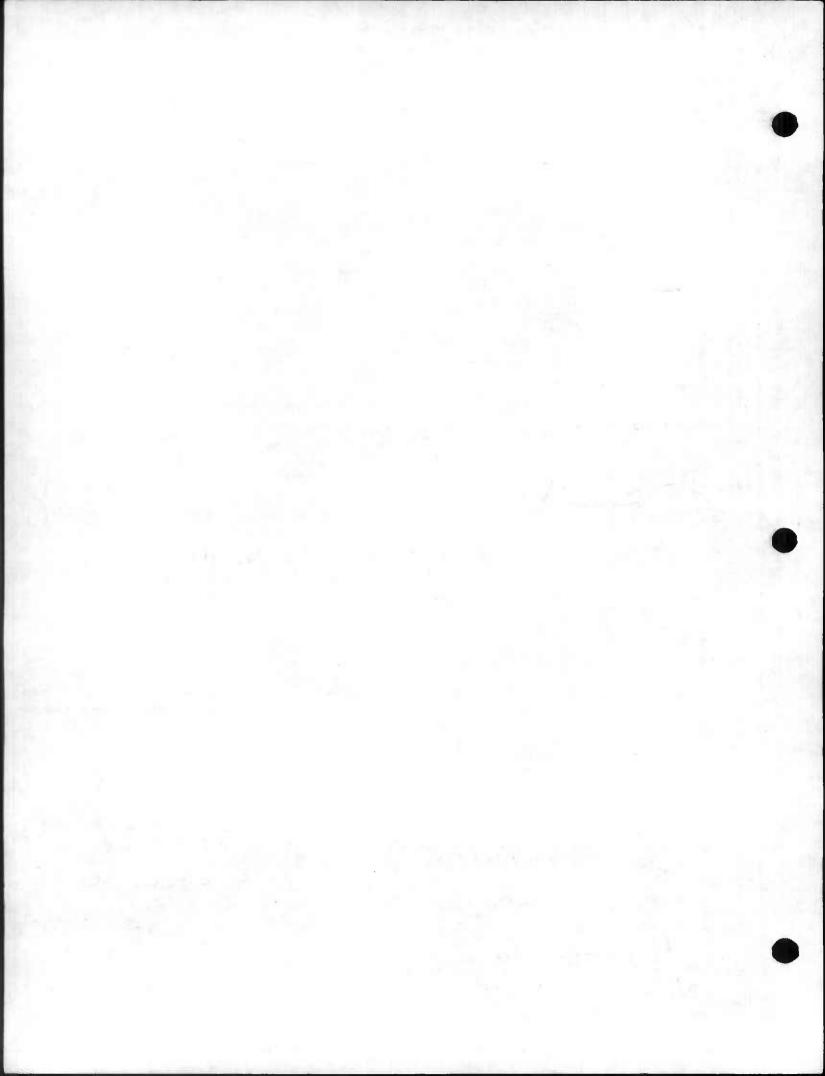
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x 68760,	ertificete be executed ding physician and se as the bunel-transit	/Medical Examiner	Sequentially list conditi- if any, leading to Immed- ceuse. Enter Underlyin Cause (Disease or Injur- that Initiated events resulting in death) Last	ions, diate ng ry	c		or as a consequ								
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ā	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely f	Certification:	3 Suicide 6 4 Homlcide	Could not be determined	28e. Place o building	g, etc. (Specif						City or To	(Street end Numb wn, State)		
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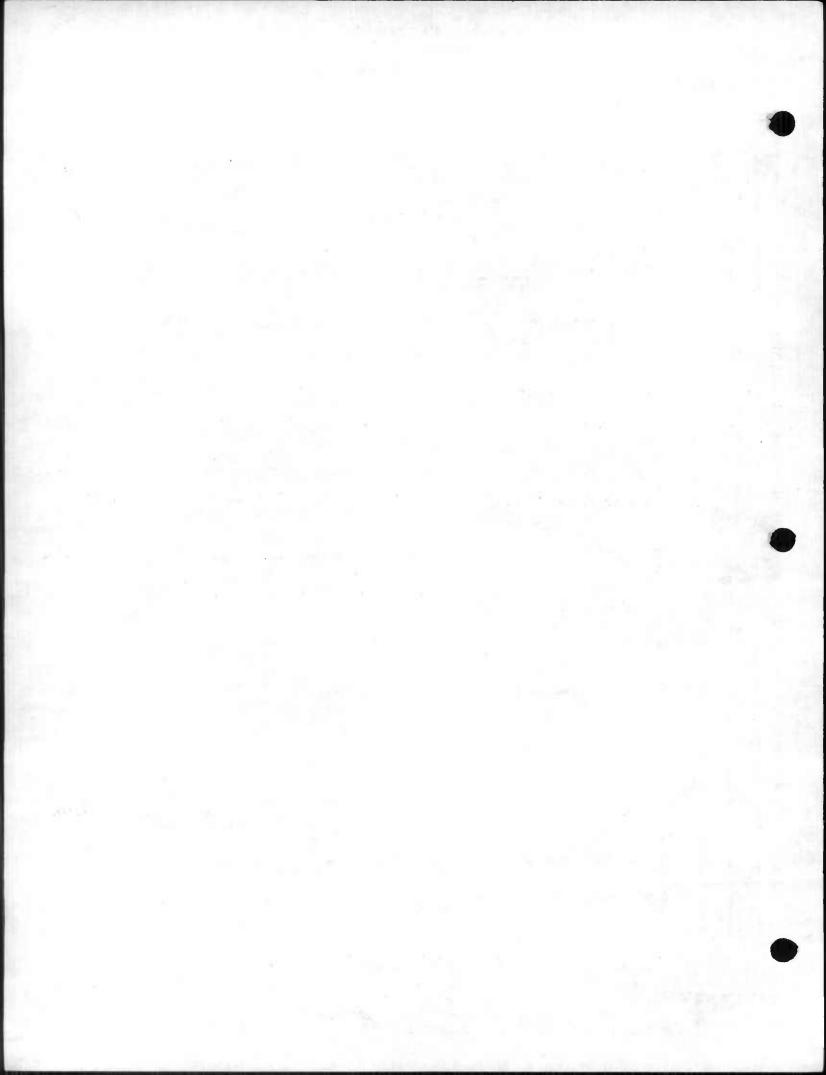


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н	Funeral		5. Social Security Number 6. S	ex XIM 2□ F		s. last birthday) Yrs.	Months De	ear If Under tys Hours	Min. (A	ate of Birth fonth, Dey,			placa (Stete or Foreign htry)	
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21215-0020	or iten	by	3 Widowed 4 Divorced		If Yes, specify (pecify Yes or No- o Rican, etc.) 14. Race - America Bleck, White, of Specify: Blad			etc.			
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7	d 2 should be the and Menta 7 is marked traumatic e	6	William Dabney Sr. Lillie Mae Black-White 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)											
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ore,	of Health of Health item 27		20a. Method of Disposition		20b.	Plece of Dispo	osition (Name of	1	De		Oc. Location -			
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	the Ho in 24 the Fu	edicai	one) 2 Medical Exam	end menn	er steted.	netion and/or in	ivestigation, in r	ny opinion, dee	th occurred et	the time, da	te end plece, e	and due to	the cause(s)	
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	11:) [clare for	be du				O.C.M.E	· •		ctober	09,	1333	
	WI		30. Neme and address of person who	KE, M	P	1	Print) 11 Penn	Street	, Balt	imore,	Maryl	and 2	21201	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 99 Bernadine Dean 08 Oct. 6:00am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2610 Ridgely Street Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 220-20-3945 1 M SENE 70 MD Director Usual Residence of Decedent The Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. Counts 28a-f show must be notified at MD NA Baltimore XXYes 2 No Director 10e Street and Number 10f Zio Code 10g. Citizen of What Country? "natural", or flams 23a or 1925 E. North Avenue 21215 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S.
Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify: Black þ ¥∰Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Se de Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if them 27 is marked other th Any Injury or other free marked other the 12th Grade NA Housewife in home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) a 10 Robert Trice Mary Cummings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Floyd 2610 Ridgley Street Baltimore, MD. 21230 Dean 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State M.D. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 10-13-99 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licenses WM.C.March FH 1101 E. North Avenue Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final holastatic. adent carechemen 1 MONTH disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physicien and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? Part It. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. signed by t 1 Yes 2 No 3 Probably V Unknown à 24b. Were autopsy tindings available prior to completion of cause of death? should Completed 24a. Was an autopsy performed? has 1 Yes 242 No 1 Tyes 2 No certificate Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Home 1 Yes 26 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Withatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifie 1@*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1219714 (Dician) 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Ave BILTIMORE pul 21224 J4BVMC 4940 IZRTERM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 9 3 | 6 7 6

			Certificate of	Death	Re	g. No.	31010		
Dhi.i	Decedent's Neme (First, Middle, Last)				2. Date of Death Month	Dey Yea	3. Time of Death		
Physician /Medical	Clare Klug Dor	ney			Oct. 10.		1:30 am		
Examiner	4e Facility Neme (If not institution, give street and	number)		4b. City, Town, or La	ocation of Death	4c. County of De	ath		
	3900 N. Charles St.			Baltimor		City			
Funeral Director	5. Sociel Security Number 6. Sex 1 M 2 M F	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 3,	1901 Ma	irthplace (Stete or Foreign Country) ryland		
2 .	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, Town	or Location				10d. Inside City Limits		
or 28a-f sho be notified at Director	Md. Balto. City	Baltin					100 Yes 2 □ No		
	3900 N. Charles St.	Apt. 1309	10f. Zip Code 21218		10	g. Cifizen of Whet to			
3 2 2 3	1 Never Merried 2 Merried 1 Yes,	ecedent Ever In U,S. Forces? s 2 1 No Give r Detes:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2000(No		ecify Yes or No- Rican, etc.)	Bleck, Wi	nerican Indian, nite, etc. White		
5-0-5	15. Decedent's Education (Specify only highest grade complete	16a.	Decedent's Usual Occup	pation	ina	6b. Kind of Busines	ss/Industry		
veithin see.		life. DO NOT use retired)					ing		
d The d	17. Father's Neme (First, Middle, Last)		1104964116	18. Mother's Nem	e (First, Middle, M	eiden Sumeme)			
Vlanc uld be it Mental H rived out file ever	Benjamin Aloyisus	Klug		Phile	omena Voe	ek			
2 should and Market Mar	19e. Informent's Neme/Reletionship (Type, Pnnt)		Meiling Address (Street	end Number or Run	al Route Number.	City or Town, State	. Zip Code)		
Magaga Market	Alva P. Weaver III		Bluestone R						
	20e. Method of Disposition	20b. Place of	Disposition (Name of	!		Oc. Location - City	or Town, Stete		
Saltimore, semit. Pages 1 a separtment of Hei mportant: If them ny injury or othe fixe.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel fro 4 ☐ Donetlon 5 ☐ Other (Specify)	m State	cremetory or other pla Crematory		, 1999 I	Baltimore	, Md.		
Ball permit Depart Impo	21. Signeture of Fammul Service Licensee	f	22. Name and Addre Eckhard 11605 R	ess of Facility t Funeral eisterstor	Chapel wn Rd.,	Owings Mi	21117 11s, Md.		
Physician /Medical	23a. Pert1. Enter the disease, or complications the shock, or heart fellure. List only one cause of Immediate Cause (Fine) disease or condition		4	0 .		st,	Approximete Interval Between Onset end Death		
Examiner	resulting in deeth)	ngestiv Due to (or as ec To cardi	onsequence of):	TOCT E			i and		
Pine si ed	b. M.	10 cardi	al In	farctro	n		weeks		
58760, icate be assected physician and street burial-transit street burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c	Due to (or as a c	onsequence of):						
be a buriclan buring	cause. Enter Underlying Cause (Diseese or injury thet initiated events								
2 5 0 5	resulting in death) Last		1						
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O. B. o death the atte hed for	Pert il. Other significant conditions contributing to	death but not resulting in	the underlying cause gi	ven in Pert t.	23b. Did tob	acco use contribu	ite to the cause of death?		
C X 70	Atrial Fibrilla	Hon			1 🗆 Ye	2 12 No 3□	Probably 4 Unknown		
s been s 2 should	Dementra				24a. Wes an perform		b. Were eutopsy findings available prior to completion of cause of death?		
The law The law page 2 Comp					1 ☐ Yes	2 10 No	1 Yes 2 No		
Vital I	25. Was case referred to medical			26. Place of Deet	h (Check only one)			
of Vita Physician: this certific ral director,	exeminer? 1 Yes 2 No Hospitel: 1	☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Ot	her		nce 6 Other (S	pecify)		
on of ding Phys h. After this funeral di	27. Menner of Death 1 Neturel 5 Pending (M	te of Injury 28b. To	ime of 28c. Inju	ry at	28d. Describe how				
isi deat deat ctor: y the	2 Accident Investigation 3 Suicide 4 Homicide Investigation 2 Accident Investigation 3 Suicide 4 Homicide Investigation 2 Be. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 2 Be. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)								
Hospi 4 hou Funer Tely fill	29e. Certifier (Check only one) 12 Certifying Physician: To to the sind m	he best of my knowledge, basis of examination and anner stated.	death occurred et the ti	me, date and place, opinion, deeth occurr	end due to the car red at the time, dat	use(s) end menner te end place, and d	es stated. ue to the cause(s)		
To the To the Comple	29b. Signeture end title of certifier		29c. Licens	se number	29	d. Dete signed (Mo	nth, Day, Year)		
m 5 m 0	M. Day	pl.	N.	1219 -		0	1990		
	39. Name end eddress of person who completed ca	se of deeth (Item 23a) (+3175		Jet 11	1/17		
	Stephen W. G	eurge, my	3900	N. CHARLE	es st #/	04 BALTI	MORE, ND ZIZIE		
State	31. Dete filed (Month, Day, Year) 32	Registrer's Signeture	oain						

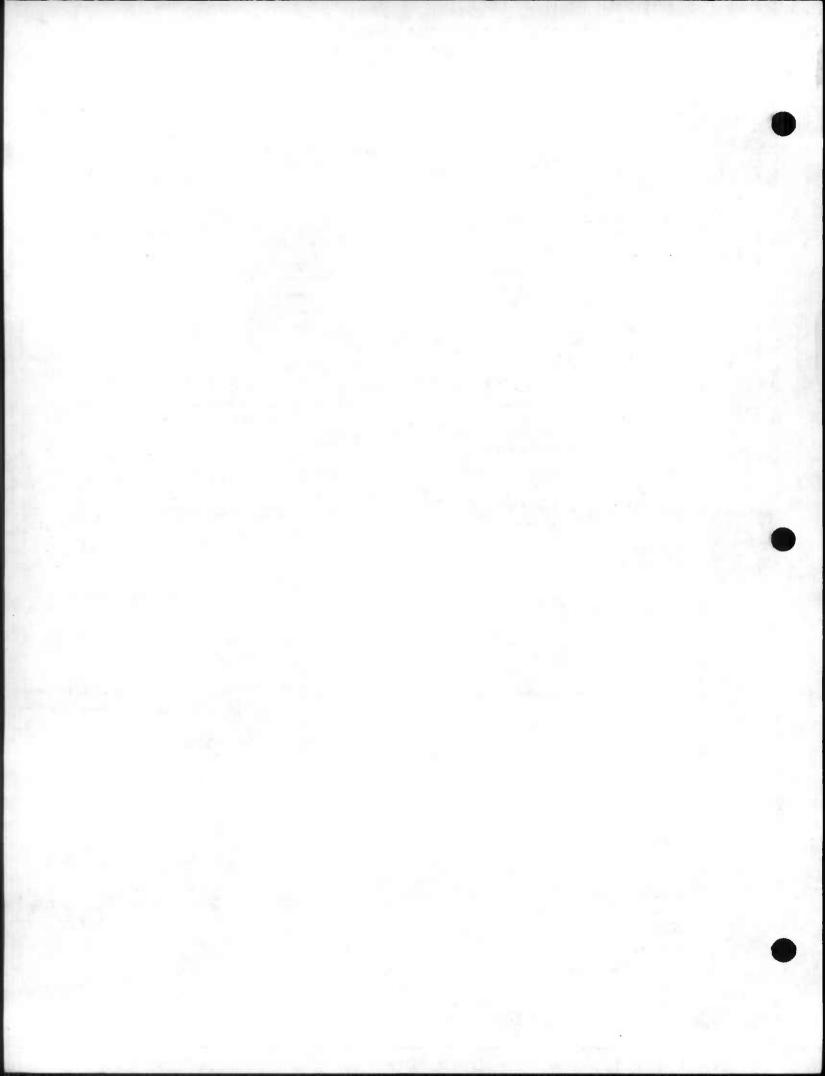
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** Antoinette C. Dement Oct. 8 1999 4:00 P.M. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Locust Lodge Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 1 M 200 F Months Deys Hours 354-22-7890 93 Yrs 1/16/06 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10e. Stete 10b. County 10d, fnside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 184 Meadow Road U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Heelth end Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: þ White 3 ₩ Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Accountant Insurance Company 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) 8 Marie Sumic Jacob Celusnick 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Heelth er Important: If item 27 is any injury or other trau P.O. Box 600 Pasadena, Maryland 21123 Denis Dement Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 XCremetion 3 ☐ Removel from Stete 10/12/99 Towson, Maryland Hilltop Service Corp. 4 ☐ Donetion 5 ☐ Other (Specify) e of Funeral Service Licensee 22. Neme end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 mora ramerous positions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, and ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Adenocarcinomo month diseese or condition resulting in death) Examiner Due to (or es a consequence of): Examiner physician and the bunal-transit The lew requires that the death certificate be asscuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physiclan/Medical Due to (or es e consequenca of) 980 P.O. signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to 24e. Wes an eutopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 ☐ No or Attanding Physician: director, 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Dother (Specify) Living Home Hospital: 1□Yes 2☑No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending s after dea. 1 Tyes 2 No 2 Accident Investigation 3 ☐ Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-9-99 Condace Chardler MD D29209 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) RAYNOR BLUD PASADENA MD 21122 CHANDLER 8096 EDWIN CANDACE MO 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

OCT 12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death AmendeDItems#12.13. perFH G776 10/15/99 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month **Physician** Desi/va 4c. County of Death Henry OCTOBER /Medical 4a Facility Aame (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BACTIMORE
If Under 24 Hrs. 8. D.
Hours Min. HOPKINS HOSPITAC If Under 1 Year 5. Sociel Security Number Sex 12 M 2□ F 7. Age (In yrs. last birthday) 8. Dete of Birth Birthplace (State or Foreign Country) **Funeral** Months Days LA Director MARCH 1 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits BERMUDA 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 02 WES INDIES 12. Was Decedent Ever in U.S. Armed Forces? Hems: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien. Pages 1 and 2 should be filed within 72 hours after nent of Health and Merital Hygiena. Int: If Item 27 is marked other than "natural", or ite ☐ Yes 2 ☐ No t Yes. Give 1 Never Merried 2 Married 21215-0020 Hnk 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced WHITE Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 +# GRADE Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be WILLIAM DE SILVA STELLA MADEIROS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 33 SUN VALLEY RD. ELIZABETH HICKMOTT WARWICK, BERMUDA WKO2 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Department of Important: If it any injury or o 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) JOHNS CEMETERY 10-13-91 PEMBROKE 22. Name and Address of Fecility BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee JOSEPH. FULTON AVE. BALTIMORE, MD. 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final death sevents tive minute disease or condition resulting in deeth) Examiner Be Completed by Physician/Medical Examiner cerebrorascular Hemorrhagic Twenty four hour Attending Physician: The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Box 68760. Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No coronary 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? heart 2 No 25. Was case reterred to medical examiner?

1 Yes 20 No 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide the critifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signetate and this of certifier 29d. Date signed (Month, Day, Year)

Registrar

Toold

31. Dete filed (Month, Dey, Year)

resident

OCT 12

physician my wto completed dause of death (Item 23a) (Type, Print)

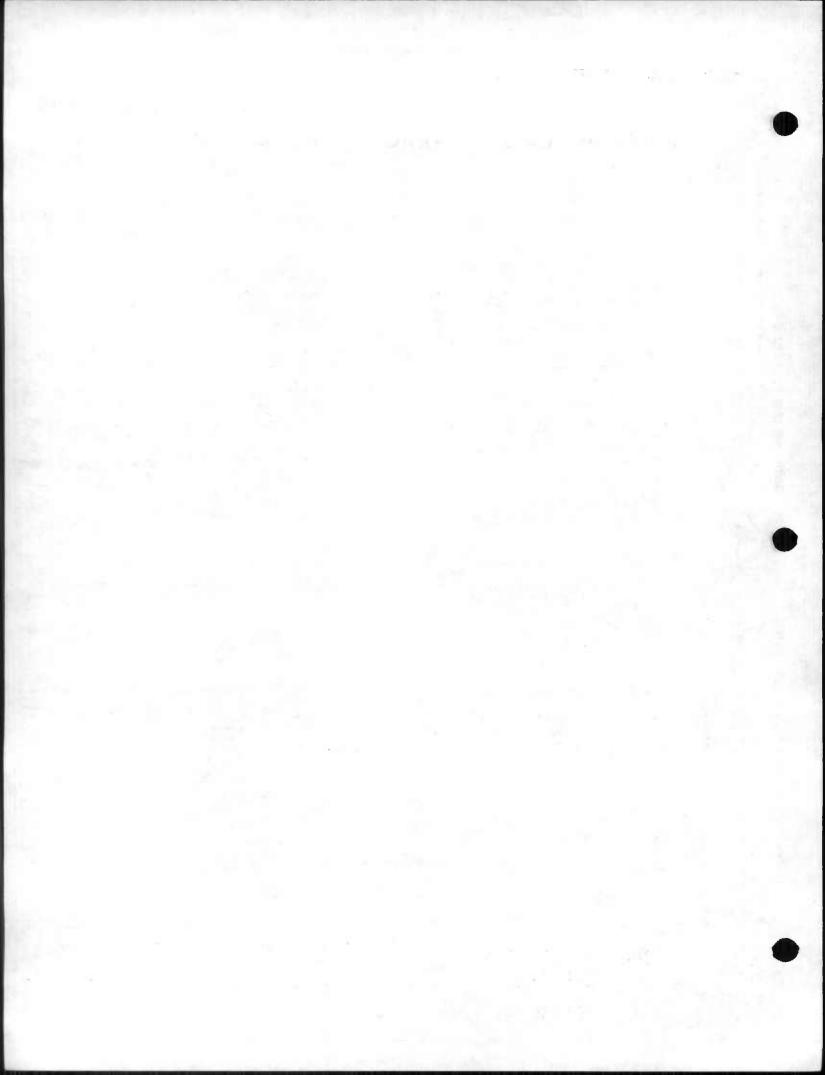
32. Registrer's Signature

Johns Hopkins Hospital

DHMH 16 Ray 6/95

October,

600 North Wolfe Street Bultimore Maryland



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death 1999^{Xaar} **Physician** October 9. Maria G. DiMarco 2:25 am /Medical 4e. Facility Neme (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Agnes Nursing and Rehab. Center Ellicott City Howard If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 212-62- 7333 1□ M 2 F 68 Yrs. Director Feb. 23. 1931 Italy Usual Rasidanca of Dacadani Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nenf of Health and Mentel Hygiene.
Int: If Item 27 is marked other than "natural; or frems 23s or 28s-f show any or other traumetic event, the Medical Examine I must be notified at 10a State 10b. County 10c. City. Town or Location 10d. fnsida City Limits MD by Funeral Director Howard 1 ☐ Yas 2 ☐ No Marriottsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 11406 Old Frederick Road 21104 Permanent Resident 12. Was Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, etc. 1 ☐ Navar Married 2 ☑ Married 21215-0020 1 Yas 2 No Specify: White 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elamantary/Sacondary (0-12) Collega (1-4or 5+) Seamstress Tailor Shop Baltimore, Maryland 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Rosario Mileo Pierina Venturella 19a. Informant's Nama/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 11416 Old Frederick Road, Marriottsville, MD 21104 Rosario DiMarco (Son) 10/12/99^{20c.} Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Spacify) Crestlawn Memorial Garden Marriottsville, MD 21. Signatura of Funeral Service Lipenses 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Entar tha diseesa, or complications that caused the deeth. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each line. Approximata Intarval Batwe Onsat and Death **Physician** CARDIOVASCULAR /Medical Immediata Ceuse (Fine DSCLEROTIC disaasa or condition rasulting in daath) Examiner Dua to (or as a consequanca of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter death.

Funeral Director: After this certificate has been signed by the ettending physician and Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that Initiatad avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760. ettending physician Physician/Medicai Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? the 3 □ Probably 4 □ Unknown signed by DIVAL 1 ☐ Yes 2 ☐ No Division of Vital Records. þ 8 24b. Wara autopsy findings eveilabla prior to Completed 24a. Was an autopsy performed? peed completion of cause of death? 2 No 1 Yes 2 No Be 25. Was casa rafarred to medical exeminar? 26. Placa of Baath (Check only ona) Hospital: Othar: 4D Nursing Homa 5 Rasidanca 6 Othar (Spacify) ဥ 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Certification: 27, Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 1 Natural 5 Panding 1 ☐ Yas 2 No invastigation 2 Accidant filled in by the 3 ☐ Sulcida 6 Could not be datamined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours e Medical 29a, Cartifian CertifyIng Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 | Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) sue 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Typa, Print) PARK HEIGHTS AVE BAUTO MI) AS NEEM AKHANI, 31. Dete filad (Month, Day, Year) 32. Registrar's Signatura State 1 2 1999 Registrar

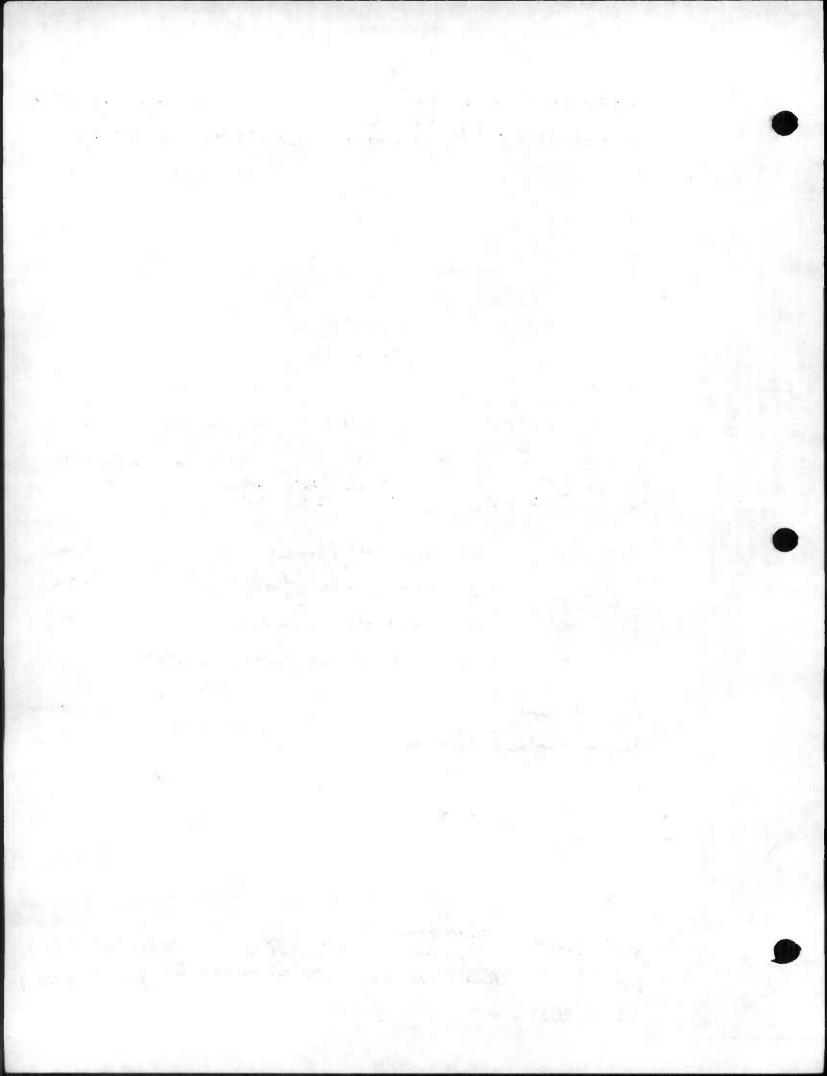


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth DUKE Month **Physician** DOROTHY 1746 10 /Medical 4e Facility Nama (If not institution, give street and number) MEDICAL 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIVARSITET BATMORE CHENDER If Under 24 Hrs. 9. Birthplaca (Stata or Foraign Country) If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Deys Months Hours 1□M XXF 216-30-2292 Director JAN 16 1927 MARYLAND Usual Rasidence of Decedent 10s State 10b. County 10c. City. Town or Location 10d. Insida City Limits X⊠ Yas 2 No Directo 28a-f 1 MARYLAND N/A BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or thems 23s or the Medical Examiner must be 1710 N MOUNT STREET 21217 II.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: BLACK à 3 Nidowed 4 □ Divorced Yaar or Datas: Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Etamantary/Secondary (0-12) College (1-4or 5+) SELF 12th grade DOMESTIC ENGINEER permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Nem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be GEORGE SMITH ELEANOR WILLIAMS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Eleanor J. Watkins/Daughter 2431 DRuid Hill Avenue, Baltimore Maryland 21217 20a. Mathod of Disposition 20b. Ptace of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State Data 1 Nourial 2 □ Cramation 3 □ Removal from Steta 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 10-13 LAUREL, MARYLAND 21. Signature of Fundral & 22. Nama and Addrass of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA Moun 1206 W NORTH AVENUE 23a. Per L'Enteutha disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvat Batween Onsat and Death **Physician** /Medical Immediata Causa (Final - anly diseasa or condition rasulting in death) Examiner MYOC burial-transit Sequantially tist conditions, if any, taading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Dua to (or as a consequenca of) and physician a the burial Box 68760. Physician/Medical Dua lo (or as a consequenca of): 88 980 0 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy parformed? Completed peeu has 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4☐ Nursing Homa 5☐ Rasidence 6 ☐ Othar (Specify) 1 Yas 2□ No Certification: To 1 ☐ Inpatient 2 € ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? After Hospital or Attending 5 Pending Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 28a. Placa of Injury - At home, farm, straet, fectory, office building, atc. (Specify) 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Steta) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and mennar as stated.

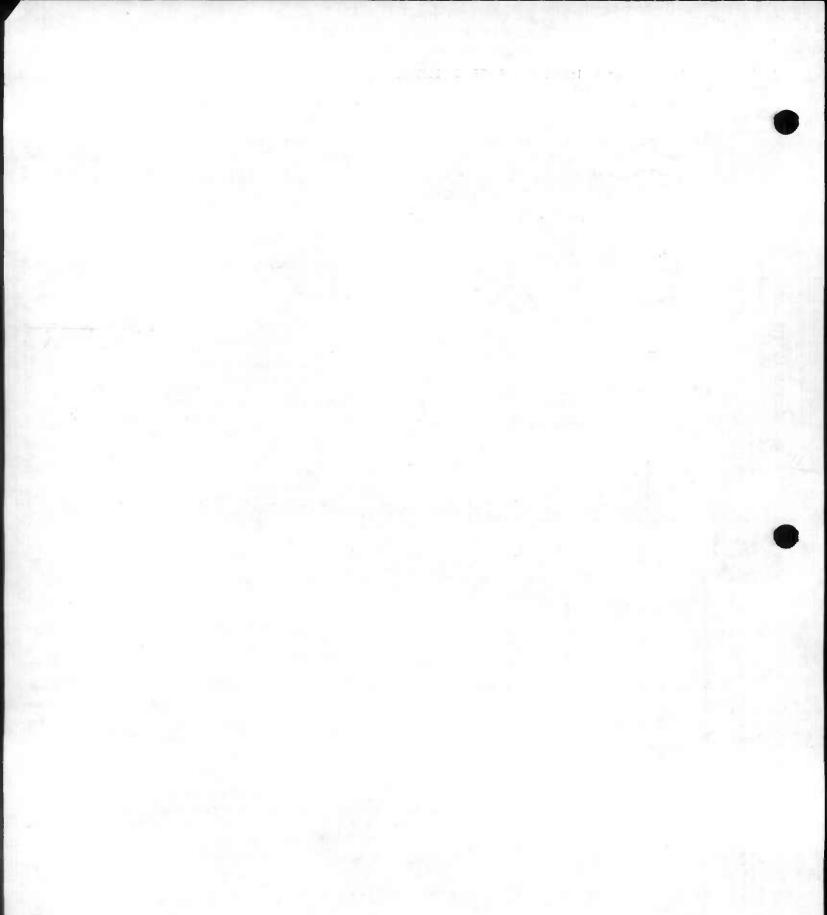
2 Madicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. Medical 29a. Cartifier completely (Check only one) 29b. Signatura and Iitla of certifier 29d. Data signed (Month, Day, Year) 28260 16 22 S. Greene St MICCAN 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, 32. Registrar's Signatura

DHMH 16 Rav 6/95

State Registrar



James R. E		em#16b perFH(•			Reg. No.	3	1681
Physician /Medical	1. Decedent's Neme (First, Middle James	, Last)		Eley	Sr.		Day	Year	3. Time of Death $16:40$
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5	North Arunde			dev) If Under 1 Year					
Funeral Director	214-30-6534	1∭ M 2□ F		Months Days	Hours Min.	1			
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aryla should I marke marke		-	19b. I	Aailing Address (Stree			er. City or Town.	Stete. Zip (Code)
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	23a Part Enter the diseese, or thought or heart feilure. List	complications thet cau only one cause on ee	used the death. Do no ch line	t enter the mode of dy	ing, such es cardiac	or respiretory e	rrest,		Interval Between
Physician /Medical Examiner	Immedia (c/C use (Finel disease of condition resulting in death)	a. Muu		Mynus of:				1	Onset and Destin
a si e		b						4	
58760, icete be executed physician and sthe burial-trensit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury)		Due to (or es a co	nsequence of):					
Box 68760, eath centificete be ax attending physicien of for use as the buriel clan/Medical E)	thet initieted events resulting in death) Last	d	Due to (or es a con	nsequence of):					
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Div affect of in by din	4 Homicide	building		V				MY MU	- brunner HID
DIVI To the Hooptal or At Within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 Certifyin (Check only one)	examiner: On the bes	est of my knowledge, of examinetion and/	leath occurred at the t	ima, date and place opinion, deeth occu	end due to the	ceuse(s) end me	nner as sta	ated.
Me Me	29b. Signature and title of certifier	Λ ν		29c. Licen	se number		29d. Dete signe	d (Month, C	lay, Year)
	1 Lounto	brelly	ll	0.C.	M.E.		October	6, 1	.999
	30. Name and address of person of MAGAMAN	who completed cause	of death (Item 23a) (T)	(pe, Print) 1 Penn Str	eet, Balt	imore,	Maryland	2120	1
State Registrar	31. Date filed (Month, Dey, Year)	1000 32. Reg	gistrar's Signature	9. Spar	es .				0.75



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State of Maryland / Department of Health and Mental Hygiene	99	31682	1
Certificate of Death			

							Ce	ertifica	ate of	Death			Reg. No.			
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5.	moral		5. Sociel Security Number	6. Sex		7. Age (In yrs.) if Unc	ler 1 Year	If Under 2		B. Date of Birt	1	1 More		Foreign
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land	N M		10a. State 10b. County			10c. Ci	ity, Town or I	Location						1	Od. Inside City	y Limits
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ath	23	ra	731 Camberley						21204				U.S.			
72 hours after death with the Maryland	r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at	Funeral	11. Maritel Stetus		Armed For		J,S. 13	If Yes, sp	pecify Cub	lispenic Orig en, Mexican,	jin? (Speci , Puerto Ri	ify Yes or No- can, etc.)		ck, White,		
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ENDED ITEM #	26	PER MD G776 10/12/99 A	.H	Marylan		artmen rtificate					leg. No.	31	683
Physic	ian	Decedent's Name (First, Middle, L			_					Date of Dea Month	th Dey	Year 3.	Time of Death
/Medi			Jean	For	d			(b. Ob. T.			3 19		a.m.
Exami	ner	4a. Facility Name (If not Institution, g		oer)						cation of Death	4c. County		
and the	7	636 Longview 5. Social Security Number 8.		Ann /In	lood & Adhido dayd	If Undar		Cato:		11e 8. Date of Birth		ltimor	
Funeral			1□ M 2□ F	Aga (In yrs. I	ast birthday) Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)	9. Birthplaca (Stata or Foraign
Director		212-20-9447 Usual Residence of Decedent	7.	76						07 11	1923	W.	VA
aryland ahow ed.et		10a. State 10b. County		10c. City	, Town or Lo	cation		_				10d. in	side City Limits
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7 28s	Director	10e. Street and Number				10f. Zip					Og. Citizan of		Δ
death with the Maryland rms 23s or 26s-f show rmset be notified at		636 Longview	Drive			21:	228				USA		
her death with the Maryla Rems 23s or 28s-f shor liner must be notified at	Funeral	11. Marital Status	12. Was Decede		S. 13.	Was Deced	lent of H	ispanic On	gin? (Spe	city Yes or No-		ca - American In	dian,
5-0020 72 hours after natural, or to		1 ☐ Never Married 2 ☐ Married	Armed Force 1 Yes 2 If Yes, Give						nican, atc.)		ck, Whita, atc.		
Ours ours Exa	1 by	3√2 Widowed 4 □ Divorced	Year or Date	as:		1□Yas 2	ZEKWO	Specify:			Specify	whi	te
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Aaryland 2 should be to and Mental I is marked of	2	John Andrew D			· · · · · · · · · · · · · · · · · · ·			Hade	die	Harrir	gton		
Maryland of 2 should be tile the and Merital Hy 7 is marked other traumatic event.		19a. Informant's Name/Relationship										State, Zip Code	
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0 80 2 2		20a. Method of Disposition 1 □ Burial 2 ♥ Cremation 3	Ramoval from Sta		lace of Dispo amatary, cre	nsition (Nam natory or of	ne of ther plac	ca)		Date	20c. Location	City or Town, S	itate
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Baltimore, permit. Pages 1 as Department of Hea important. if Item.! sny Injury or other once.		21. Signature of Funeral Sarvice Lice	ingee/			. Name and				- 1		ral Ho	
Physician /Medical		23a. Party. Enter the disease, or con- ended, or heart failure. List only Immediate Cause (Fine)			Do not ent	36 E ar tha mode	dmo: a of dyln	nds or g, such as	n Av cardiac or	enue,	Balto est,	Md 2 Appr	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlet-transit and completely filled in by the funeral director.	edicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	a. <i>Chron</i> b	Due to (or	as a consequence as a c	quance of):	Ph		auy	arsio	ŞE		uonin
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Division of Vital Records, or Attending Physician: The law requires the effect death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed b							_	atti dili diperiti di serio di serio di serio di serio di serio di serio di serio di serio di serio di serio di	24a. Was a perfor	in autopsy med?	24b. Were at available complet of death	atopsy findings s prior to ion of cause ?
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ysic of its cell dire	0	1 Yes 2 No	Hospitel: 1 ☐ Inp	atient 2	ER/Outpetier	# 3□ DO	A Oth	er: 4□ Nu	ırsing Hom	ne 5 Resid	ence 6 Oth	ner (Specify)	
Jn O fing Ph After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	21	8c. Injur Wor	y at k?	2	8d. Describe h	ow Injury occur	red	
SiOI eeth. wr. Af	atic	2 ☐ Accident investigation	on		,,	М		Yes 2	No				
Divis	Certification:	3 ☐ Sulcide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of	Injury - At ho , etc. (Specify	me, tarm, str	eet, factory	, offica		2	8f. Location (S City or Tow		ber or Rural Rou	te Number,
Divisio To the Hospital or Attendit within 24 hours efter deeth. To the Funeral Director: A	edicai	29a. Certifler (Check only one) 1 ✓ Certifying P 2 ☐ Medical Exa	hyelcian: To the be miner: On tha basi and manner	s of examinat	vledge, death ion and/or Inv	occurred a vestigation,	in my o	ne, date an pinion, dea	d placa, a th occurre	nd due to the d d at the time, d	ause(s) and ma late and pleca,	anner as stated. and due to the o	cause(s)
To the Com	Σ	29b. Signature and title of certifier	111	_				a number				d (Month, Day,	
		· Vu Tro	MILLER	mo			75	033	8		oct. 4	MD 2	
		30. Name and address of person who	completed cause	of death (Item	23а) (Туре,	Print)		, 1				-	
		Pio L. Poblete	M.D.	11055	Little	Patu	(xel	Et Par	Kwa	Colu	mbia	MD 2	1044
Sta Regist		31. Date tiled (Month, Dey, Year)	32. Reg	Istrar's Signat	ure	4	100	11		1		7	

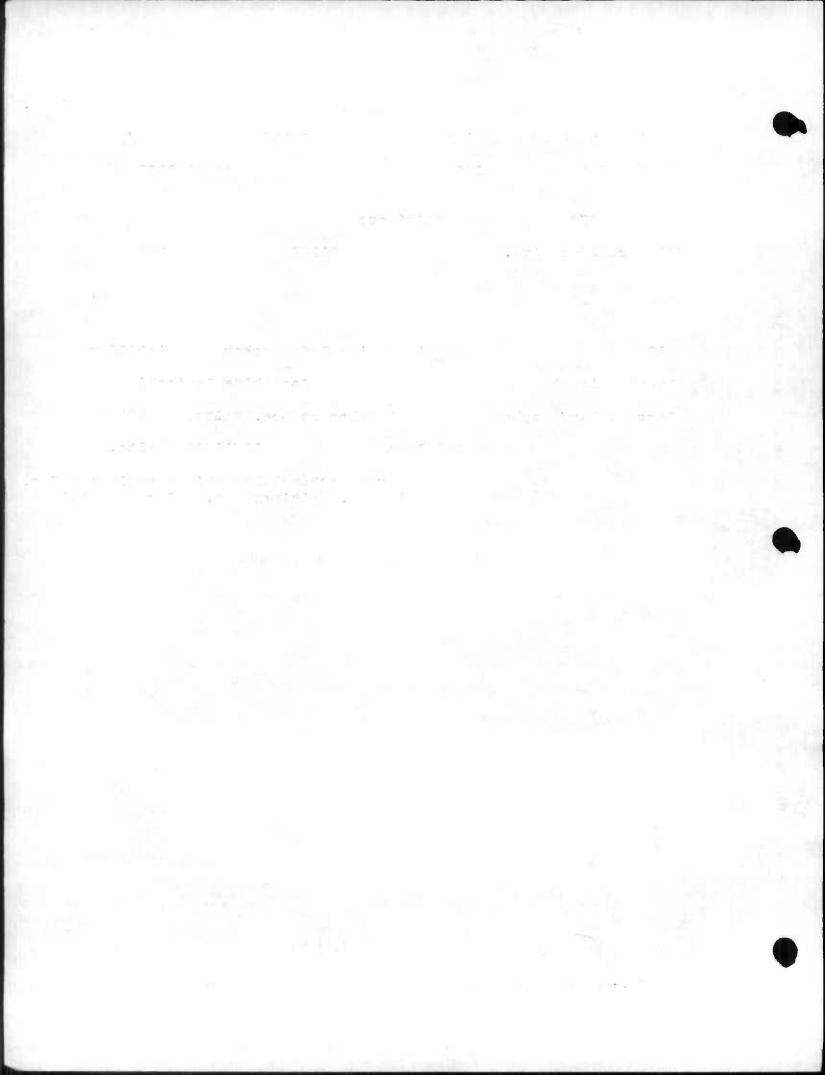
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ATTENDED TO CHARLES BETTER and that publishers are about

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Year 1 1991 4c. County of Death Month **Physician** FUELLER OCTOBER 9:35 P.M JOSEPHINE /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death Examiner Lorien Frankford Nursing Home Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 02 21 1897 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 10 M 20 F 216 05 5699 102 MD Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1,□ Yes 2□ No Director 280-7 MD N/A Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò 5009 Frankford Ave. 21206 USA 238 Funeral Nema 3 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 'natural', or If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify Specify: 3 3⊡Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other then Elementary/Secondery (0-12) College (1-4or 5+) Head Line Lady Packer Distillery 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Frank Dziennk Josephine Lewinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Reletionship (Type, Print) Larry Daley/ Nephew 4402 Ashcrest Ave. Balto, MD 21206 Important: If Item 27 any Injury or other to 20e. Method of Disposition 20b Place of Disposition (Neme of Date 20c. Location - City or Town, State Oak Lawn 10/11/ 99 Balto. MD 1 XBurial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Moran-Ashton-Dabrowski Funeral Home Inc. GK-Marshall 3000 E. Baltimore St. Balto, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in death) ALZEMP] MERLS YRS Anunciero Examiner Due to (or es a consequence of): Examine ician and burial-transit The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence ot) physician s the burial Box 68760. Physician/Medical Due to (or as a consequence ot): 88 1180 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown BNEMIA BSCUD þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? should Completed page 2 s hes 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case reterred to medicel examiner? Certification: To Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attanding 5 Pending investigation 24 hours after death.

Funeral Director: A 1 Yes 2 No 2 Accident 8 Could not be 3 ☐ Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify) filled In by 4 Homicide Hospital 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. completely 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) within 2 To the 29b. Signeture end title of partitier 29c. License number 29d. Dete signed (Month, Dey, Year) 10/8/99 30. Name end eddress of person who completed ceuse of death (Item 23e) (Typa, Print) OR. 耳330 LOUIND 21 C GOSS ROMDS MIUS 21117 GITTEN 31. Dete filed (Month 32. Registrer's Signeture State 1999 souks Registrar

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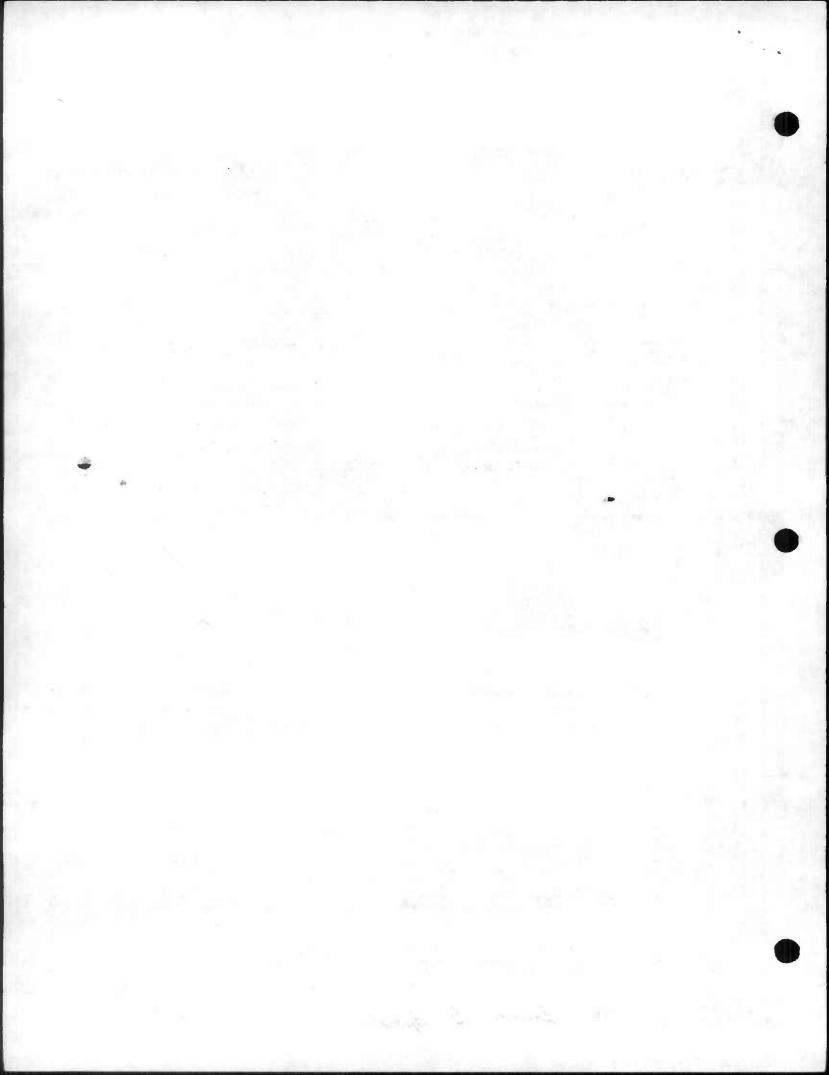
State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. No.	685
	Physician	1. Decedent's Name (First, Middle, Last)	TCD	2. Date of Month	Day Year	. Time of Death
-	/Medical	LARUE FORS	IFK	OCT		3:55 PM
	Examiner	4a Facility Name (If not institution, give street and number)	. 1	4b. City, Town, or Location of De		
		Howard County General Hospi 5. Social Security Number 6. Sex 7. Age (In year)	tal s. last birthday) If Under 1 Year	Columbia If Under 24 Hrs. 8. Date of I	Howard 9 Rightholese	(State or Engine
	Funeral Director	216-03-6448 Usuel Residence of Decedent	Yrs. Months Days		Day. Year) Country) 24, 1912 Pennsy	(State or Foreign Lvania
	how		City, Town or Location			Inside City Limits
	ith the Marylar or 28a-1 show a notified at		licott City			1 ☐ Yes 2 ☑ No
	after death with the Maryle or items 23s or 28s-1 show infrat must be notified at a Funeral Director	3004 N. Ridge Road		1043	10g. Citizen of What Country? U.S.A.	
21215-0020	S - 1 0	11. Marital Status 1 □ Never Married 2 □ Merried 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Yeer or Dates:	U,S. 13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Specify Yes or pan, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - American I Black, White, etc. Specify: White	
5-0	ed within 72 hours ygiene. Per than "natural", It, the Medical Evil.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done	pation during most of working ed)	t6b. Kind of Business/Industr	ry
121		Elementary/Secondary (0-12) College (1-4or 5+)	Clerical	9d)	Banking	
	Hygiene. Hyg	17. Fether's Name (First, Middle, Last)		18. Mother's Neme (First, Midd		
an	should be filed withing the Mental Hygiene. marked other than imatic svent, the Mental To Be Comp	Earl Sells		Stella Wilt		
Maryland		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree	and Number or Rural Route Num	nber, City or Town, State, Zip Coo	de)
	CHNL	Alma Douglas (Sister)	1 0	Gate Road, Cato	nsville, MD 21	1228
Baltimore,	nit. Pages 1 an arment of Heal ortant: If Itam 2 Injury or other &	4FI 2 11 2FI 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Place of Disposition (Neme of cemetery, cremetery or other place place) Place Park Center Place Park Center Place Park Center Park Center Park Park Park Center Park Park Park Park Park Park Park Par	netery 10/12/9	9 Woodlawn, Mar	
Balt	pemit. Page Department of Important: If any Injury or once.	21. Signature of Euperal Service Usansee		ess of Fecility Witzke Fundson Avenue, Ca		
		23a. Part1. Enter the diseese, or complications that caused the dea shock, or heart failure. List only one cause on each line.	ath. Do not enter the mode of dy	ing, such as cardiac or respiratory	r arrest, Ap	proximete erval Between
68760,	Andicate be executed the control of	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	(or as a consequence of): NARY ART (or as a consequence of):		RE two RTENSION to LATION or	
Box	at the death certifica by the attending phetached for use as the tached for use as the physician/Med	d. VIII VI	ALIIS (IT-TI)	NI DIDE	OL IIV	a yenes
	the at the A hed for ysici	Part tl. Other significant conditions contributing to death but not re	sulting in the underlying cause g	iven in Part t. 23b. D	id tobacco use contribute to the	cause of death?
P.0	that the de by the detached	REMAL INSUFFIC	TENCY	1	Yes 2 No 3 Probabl	ly 4 Unknown
Records,	The law requires that the death certate has been signed by the attending page 2 should be detached for use Completed by Physician/N			24a. W	rformed? availab	autopsy findings ble prior to etion of cause th?
Be	The law ata has page 2			11		es 2 No
ita		25. Was case referred to medical		26. Place of Death (Check on		
of Vital	Physician: rthis certific ral director,	examiner? 1 Yes 25 No Hospital: 1 Inpatient 2	□ER/Outpatient 3□ DOA	ther-	esidence 6 Other (Specify)	
ion o	of the Po	27. Menner of Death 1 KNatural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	28b. Time of Injury M 28c. Injury M	ory et 28d. Descrit ork?] Yes 2 □ No	e how injury occurred	
Division	Let or Attending P rs after death. let in by the funer led in by the funer Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of tnjury - At building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc. (Special Could not be determined building, etc.)	home, farm, street, factory, office		n (Street and Number or Rural Ro Town, Stete)	oute Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the it Medical Certificati	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my kn cone) 2 Medical Examiner: On the basis of examinand menner stated.	owledge, death occurred at the tation and/or investigation, in my	ime, date end place, and due to to opinion, death occurred at the time	ne cause(s) and manner as state e, date and place, and due to the	d. a cause(s)
	Total Company		CARDIONALIST MAR	Se number YLAND D0041711	29d. Date signed (Month, Day	, Year) 999
	May	30. Name and address of person who completed cause of deeth (Ite TONATHAN SAFREN MP	2449 MILKENS	AVENUE SUITE	300 BALTIMORE, MA	PhAND 21220
	State Registrar	OCT 1 2 1999)	Harure Property			

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

*	Certificate of Maryland / Department of Health and M	Reg. No.	99 31686
Dhariaian	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death
Physician /Medical	JEUN M GRAY O	4 .	noth 1985 072
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo.	cation of Death 4c. (County of Death
№	5. Social Security Number 6. Sex 2. Age (In vrs. last birthday) If Under 1 Year I ff Under 24 Hrs.	more	MA
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Year) DEC 23, 1	9. Birthplace (State or Foreign Country) 9.13 Mary/s MO
P & m	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Meryle Hebov	Maralas N/B BAltimore		1 das 2 No
offer deeth with the Meryland reference 23a or 28a-f show where must be notified at Funeral Director	10e. Street and Number 2500 W. BELVEOERE AVE 2/2/5		en of What Country?
5-0020 72 hours effer death natural, or frame 23 and Examiner must	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes, Sive 1 Yes, Specify Cuban, Mexican, Puerto I Yes, Sive 1 Yes, Specify:		4. Race - American Indian, Black, Whita, atc.
72 houn	3 U Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16h Vin	d of Business/Industry
within then.	(Specify only highest grade completed) [Give kind of work done during most of working to the complete of the	50C	NINISHATION
other vent.	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maiden S	
	JAMES Pulley Edna (woodfold	K
Taryis 2 should end Mer 1 mark eumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		
C = 01 h	Edwa Pulley MUTHER 2459 W. Coldsprin		BALHMOR, Rd
0 00 2 2	4 Donation 5 Dother (Specify): To Laborate (LODO O Chrun Conditory)	11/98 WO	eation - City or Town, Stata OUDCANN, Marylon
Baltim permit. Pag Department important: I eny injury o	21. Signature of Funeral Service Lipopeneo 22. Name and Address of Facility CA 55 40 Res STERIA Belfinere, May	FUN REAL	Impis F.H.
	23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac o		Approximata Interval Between
Physician	Est only the cause of astar and.		Onset and Death
/Medical	Immediate Cause (Final disease or condition as Eo/ Pulmonal 4		
Examiner	resulting in death) Due to (or as a consequence of):		
D # of	b. Sarcoldosis		i
8760, see be executed hystician and the burlei-transit dical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c.		
	that initiated events		
W =	d		
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		1 ☐ Yes 2 ☐	2No 3 Probably 4 Unknown
requirements been should		24a. Was an autops performed?	24b. Ware autopsy lindings available prior to completion of ceuse of death?
C : 48 E		1□ Yas 2□	No 1 Yas 2 No
f Vital yelden: The s certificate director, pag	25. Was case referred to medical examiner?	(Check only one)	
2 00	Hospital:	ne 5 Residence 6	Other (Specify)
ding Ph After th funeral	1 ØNatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how injury	occurred
Division of the Hospital or Attending Phy within 24 hours effer deeth. To the Funeral Director: Affer thi completely filled in by the funeral Medical Certification: 7	2 Accident investigation M 1 Yes 2 No	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
DIVISION To the Heapital or Attendible 24 hours after deet To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and at the time, date and p	and menner as stated. place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier 29c. License number	29d. Data	signed (Month, Day, Year)
- > - 0	Danilla America 10 121252	10	10199
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	101	0161
7-7	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Don Back Sal 241 (VV Backelan Acce 31. Date filed (Month, Day, Year) 32. Registrar's Signature	- Buttie	ner, MO ZIZIS
State Registrar	OCT 12 1999 Server G. Longel		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death AMEND#1 PER MD. G776 10-21-99 J.A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death HALLIE EILEEN GROSSMAN **Physician** OCTOBER 04 4:15 PM Baby Girl B /Medicai 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** 1□ M 21 F Yrs. **Director** None 32 10/4/99 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show must be notified at Director 1 ☐ Yes 2 KNo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8844 Pennsbury Place Hurrie 23a 21237 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 'rhatturaf'. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) N/A N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 2 should be fi and Mental F mportant: If Item 27 is marked William Grossman Dianna J. Deitrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hoanth G.B.M.C. PATHOLOGY 6701 N. CHARLES ST. TOWSON, MD. 21204. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 8 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) GREEN MOUNT CREMATORY10/07/99 BALTO., MD. 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final Shock 9 hours disease or condition resulting in death) Due to (or as a consequence of): Examiner Intracranial and Retroperitoneal Hemorrhage 9 hours The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieled events resulting in deeth) Last and Due to (or es a consequence of) Severe Prematurity physician 9 hours 68760 Physician/Medical Due to (or as a consequence of) attending | Box Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of causa of deeth? cate has 1 XYes 2 □ No 1 XYes 2 No Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifics stely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 X Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accidant 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours afte To the Funeral Dir 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D27740 10/5/99 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GBMC 6701 N. Charles St. Baltimore, MD 21204 Robert A. Palermo MD 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 2 1999 Registrar

DHMH 16 Rev 6/95

SKODJMAN,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#5 PER F.H. G777 11-9-99 J.A. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Gaither arbro Vernice tope 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITA If Under 24 Hrs S. B. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplaca (Stele or Foreign Country) Days Months Hours 1□M 2×F 54 Yrs. Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No MARVLAND COUNTY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ASTER USA RIVE 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giva 1 Never Married 2 Merried 1 Yes 2 No Specify: BLACK Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12+HGRADE TEACHER A. A CO. PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WOODROW ORINE DORSE OHNSON 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. tnforment's Neme/Reletionship (Type, Print) 1216 ASTER DRIVE, GLENBURNE, MD. 2106 ce of Disposition (Neme of Dete 20c. Location - City or Town, State UGENE L. GAITHER 20b. Ptece of Disposition (Name of cemelery, cremetory or other place) 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State CROWNSVILLE CEMETER 10-13-99 CROWNSVILLE, MD, 4 □ Qonetion 5 □ Other (Specify) are of Funeral Service Lice 22. Name and Address of Fecility BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE MO. 212. 21. Signal 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, book, or heart feiture. List only one cause on each line. BALTIHORE, MD. 21217 Approximete Intervet Between Onset end Deeth Immediete Cause (Finat METASTATIC colon 1 year disease or condition resulting in death) Due to (or es e consequence of) failure renal Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) infection Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 121No 1 Yes 2 No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospitet: 1 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred 1 DNeturat 5 Pending investigation

Examiner or Attending effer death. Director: Aft

Examiner Physician/Medical à Completed Be Certification: To in by

Physician

/Medical

Examiner

Funeral

à

Completed

Be 2

Funeral

Director

- how

21215-0020

altimore, Maryland

Pages 1 and 2 should be fill ment of Health and Mental H ant); if them 27 is marked off jury or other traumatic even

Physician /Medical

24 hours Funeral Medical To the Hosp within 24 ho To the Funs completely t State

POUR

Registrar

-01m-

6 Could not be

MD

28e. Pleca of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number D40850

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

October 8, 1995

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OTTAVIANO MD GUD CATON ALE BALTMORE MID 21229

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Yellir)

2 Accident

3 Suicide

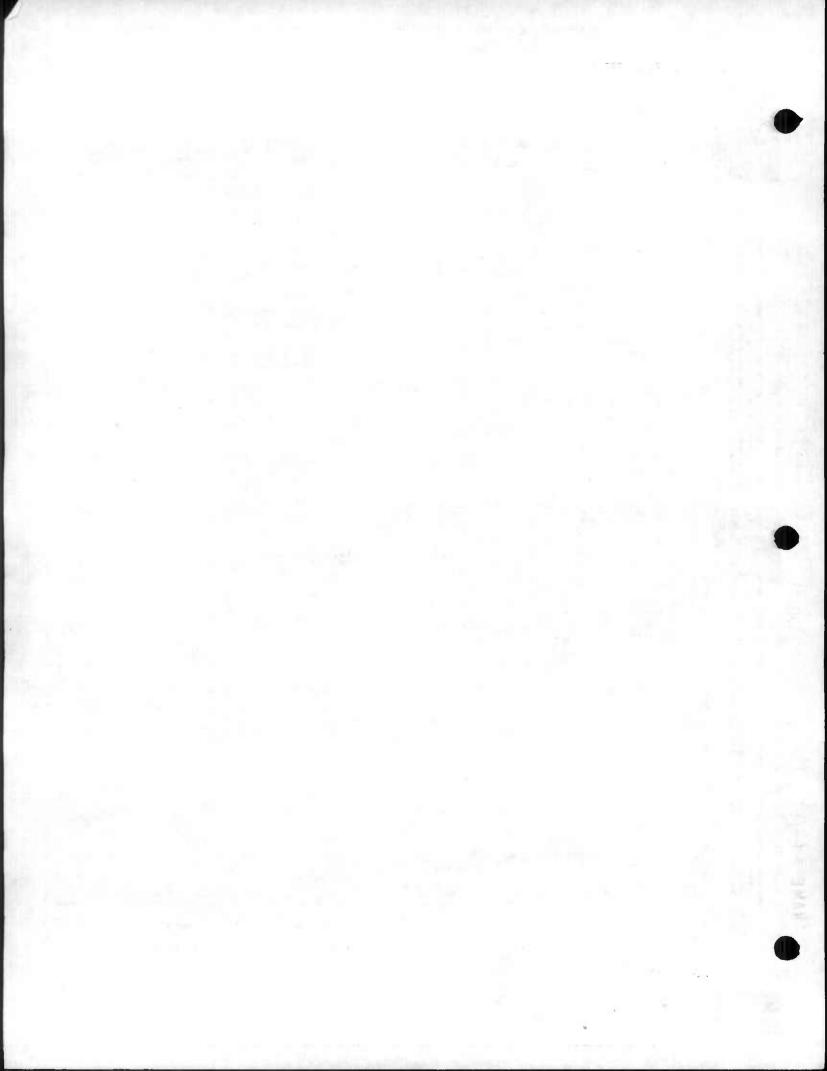
29a. Certifier

4 Homicide

(Check only one)

29b. Signetura end titla of certifier

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Maurice GHEE ctober 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number, 4c. County of Death Baltimore General naryland If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary and 6. Sex 1☑M 2□F Yrs. 220-64-7588 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Naryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ILSA Parkiteights Ave 21215 6524 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2₽No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Temp Agency ustodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hi Mary Roane George Ghee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 6508 Brother Park/Heights Are Balto, MD 21215 Vernon GHEE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Zion Cemetery Oct, 13,99 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signeture of Funeral Service Licensee Ronald A. GRAYSON Funeral Service 8312 Liberty Ruad Ballo Md 21244 a. Man Minaca 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Syndrome ticiency Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No

been signed by tha attanding physician and should be datached for usa as tha burial-Iransit Division of Vital Records, P.O. Box 68760, tha this cartificata Aftar death.

Physician/Medical

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Completed

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Certification:

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Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

ortant: if item 27 is marked other than "naturel", or items 23s or 28s-1 show Injury or other traumatic event, the Macical Examiner must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar c Department of Haelth and Mantal Hygiana. Important: If Item 27 ia marked other than "naturel". ~ 2002.

Physician /Medical

Examiner

naurie

with the Maryland

filled in by the funeral director, To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All complately filled in by the fu

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Neturel 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Homicide **Iffying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

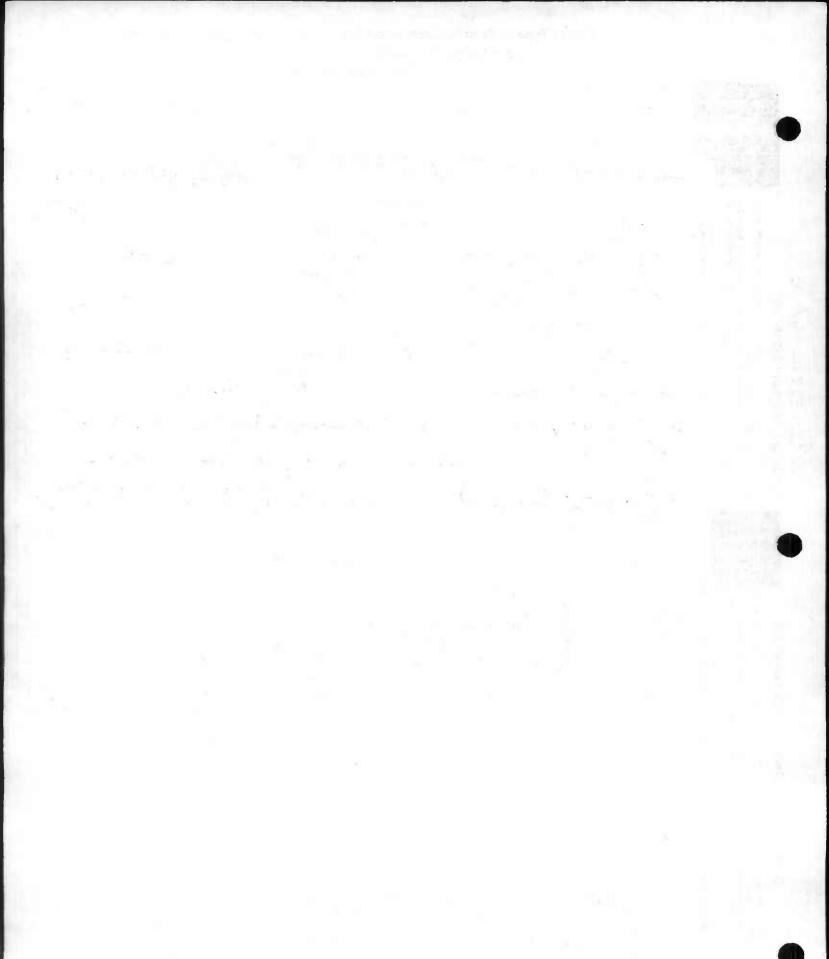
**Horizontal Examinar: On the basis of examination and/or Investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of confine

29c. License number 29d. Date grand/(Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) Paryland General rancalus, 32. Registrar's Signature

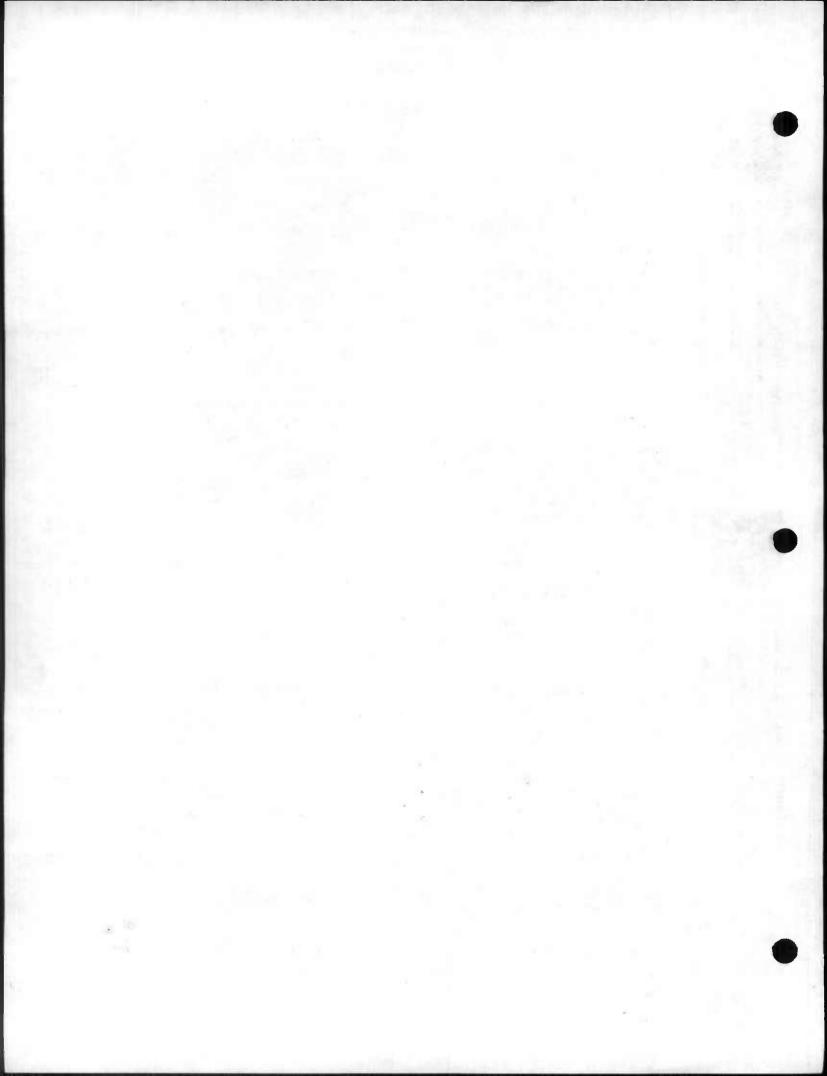
State Registrar



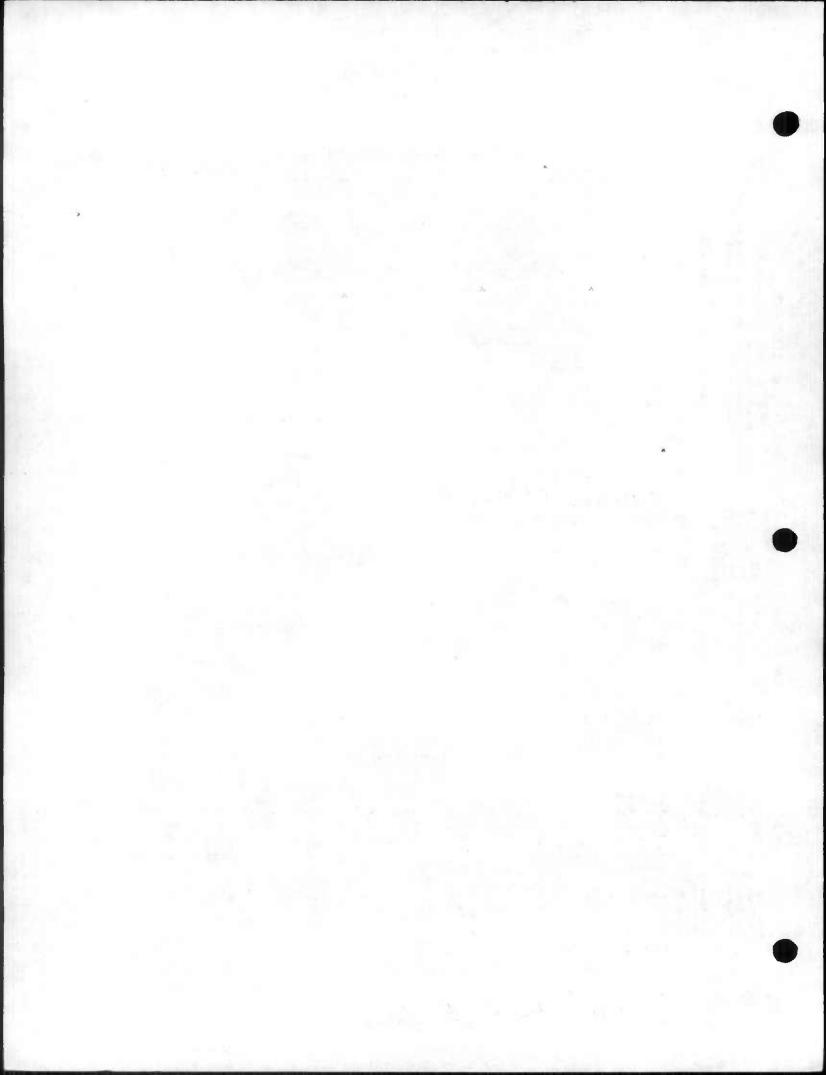
State of Maryland / Department of Health and Mental Hygiene 9 9 3 | 6 9 0

				Cer	tificate	e of	Death			Reg. No.		1020	
	1. Decedent's Name (First, Middle	e, Last)							2. Dete of De	ath	V	3. Time of Death	7
Physician /Medical	ESTHER	В.		GRI	EENBEI	RG			OCTOBE	R 7, 19	999	7:47 AM	
Examiner	4a Facility Name (If not institution JEWISH CONVALE		or)			•	4b. City, To		ocation of Death	4c. Cour	nty of Death	RE	
Funeral Director	5. Social Security Number 217–16–5520A	6. Sex 1 □ M 2KX	Age (In yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De SEPT.6	, 1913	9. Birthp Coun	lace (State or Foreign try) POLAND	
Maryland 4 show led at	Usual Residence of Decedent 10a. State 10b. County MD BALTI	MORE	10c. City, Tov		cation						1	0d. Inside City Limits 1 ☐ Yes 2 No	
with the Ma he or 23e-fe Libe notified	10e. Street and Number 5 SUNTOP COURT	#102			10f. Zip	Code	21209	3		10g. Citizen o		itry?	_
020 un after death v sit, or thems 23a Examinat mast by Funeral	11. Marital Status 1 Never Married 2 X Marr 3 Widowed 4 Divorced	12. Was Deceder Armed Force; 1 Yes 2 If Yes, Give Year or Dates	\$? 3 No		Vas Decede i Yes, speci		lispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		lece - Americ lleck, White,		
Maryland 21215-0020 d.z. should be fised within 72 hours at a 22 should be fised within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic event, the Medical Example To Be Completed by I	15. Deceden (Specify only higher Elementary/Secondary (0-12)			(Give	lent's Usuel kind of work DO NOT use	k done	during mos	at of work	ing	16b. Kind of	Business/Inc	dustry	
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/lan blod be dental rked a fo B	ABRAHAM		WA	LD			ROSE	C				KING	
CHNL	19a. Informant's Name/Relations SHIRLEY ADDIS								ral Route Numb				
altimore, mit. Pages 1 at partment of Hea portant: it Nem? y Injury or other RS.	20a. Method of Disposition 1X Burial 2 Cremetion 4 Donation 5 Other (S)		20b. Place 0	of Dispo	sition (Nam netory or oti	e of her plea	ce)		Dete 0-8-99		n - City or To	wn, State	
Balti permit. Departm importa any inju	21. Signature of Funeral Service	Licensee			. Neme and			ty SC	OL LEVI	NSON &	BROS.		
	23a. Part1. Enfer the disease, or shock, or heart feilure. List	complications that caus only one cause on each	ed the death. Do line.								ا رادادادا	Approximete Interval Between Onset end Deeth	-
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	CE	REBA	1001	7500	CA	X H	fee	100	TY		wks	
P # July		- ATTE	Due to (or as a	conseq	uence of):	A	Dio	Ms	cacas	1 D	2	YRS	
58760, cate be associed physicien end s the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	· A	Due to (or es e	conseq	vence of):	N					,	YKS	
M Bing	that initiated events resulting in death) Last	d	Due to (or es e	consequ	uenca of):								
O. Box	Part II. Other significant condition	ns contributing to death	but not resulting	in the ur	nderlying ca	ıuse giv	ven in Pert I	1.	23b. Dld	tobacco use	contribute to	the cause of death?	_
ds, P.O. Boy	ATRIAC	- PIB	MICCI	4	175	M			10	Yes 2 N	o 3□ Pro	bably 40 Unknown	1
() _ 0 0									24a. Wes	en autopsy med?	ev	ere autopsy findings elleble prior to mpletion of cause death?	
= F # & O	05.00								10	1	10	Yes et No	
Of Vital Physicien: The physicien: The conflication, print director, print of the conflication of the conf	25. Was case referred to medical examiner? 1 Yes 2	Hospitel	tient 2 ER/O	utnation	t 3 DO	Oth	or I	_	th <i>(Check</i> only one 5 ☐ Resi		Wher /Snacil	(d)	_
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Division C to the Hospital or Attending P Within 24 hours after deeth. To the Funeral Director. After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of I	njury - At home, letc. (Specify)	erm, stri	eet, tectory,	office			28f. Location (City or To	Street and Nu wn, State)	mber or Rure	al Route Number,	-
Hospi 24 hour Funer staly fill dical	29a. Certifier Cortifyin (Check only one)	g Physician: To the bes Examiner: On the basis and manner:	of examination ar	e, death	occurred a	t the tir in my o	me, date er opinion, dee	nd plece, oth occur	end due to the red et the time,	cause(s) end date end plac	menner es s e, and due to	tated. the cause(s)	-
To the within 2 To the comple	29b. Signature and title of certifier	1115			29c.	Licens	e number	3	3	29d. Date sig	ned (Month,	Day, Year)	
	30. Name and address of person	who completed cause of	death (ftern 23a)	(Type, I	Print)	93	777	ee	10	D	1 11	SYNCLEAN	-
State Registrar	31. Date filed (Month, Day, Year)	2 1999 32. Regis	prar's Signature	B	. 1	000	Kal						E

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	Decedent's Neme (First, Middle,	Last)		Cer	tificate of	Dealli	2. Date of De	Reg. No.	<u>ل ال</u>	3. Time of Death
hysician /Medical	Lyrian M. House			- 100			Octobe	r 7,1999	Year	12:240
Examiner	4a Facility Name (If not institution, John Hopkins Bay		nber)		11.44	4b. City, Town, or Baltimo:		h 4c. County		
ineral rector	5. Sociel Security Number 212–28–0912	3. Sex 1 1 2 M 2 □ F	7. Age (In yrs.	last birthday).	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min	8. Dete of Bir (Month, Dr Aug. 5	th Yard 30	9. Birthpi Coun Penns	lece (Stete or Foreign try) Sylvania
ž	Usual Residence of Decedent 10e. State 10b. County		10c. Ci	ty, Town or Lo	cation				10	0d. Inside City Limits
28a-f show notified at ector	Maryland N/A		Bal	timore						1 Yea 2 No
funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	Whet Coun	try?
erai	719 S. Bouldin S	12. Wea Dece	dent Ever in L	J.S. 13. V	21224		Specify Yes or No	USA 14. Rac	e - Americ	an Indian.
by	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed For	ces? 2 😰 No e		Ves Decedent of H Yes, specify Cub	an, Mexican, Pue	to Rican, etc.)		ck, White, o	etc.
eted	15. Decedent's (Specify only highest			(Give I	ent's Usuel Occup	during most of wo	orking	16b. Kind of B		
Completed	Elementary/Secondery (0-12)	College (1	-4or 5+)		O NOT use retire	•		Constru	ictio	n
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To	Fenton Houser					Esther	Beaver			
To	19e. Informent's Neme/Reletionshi Delores A. House				Address (Street S. Bould:					
	20e. Method of Disposition			Plece of Dispos	sition (Neme of setory or other pla	na)	Dete	20c. Location	City or To	wn, Stete
	1 ■ Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spe		STATE		art of Je		10/11/9	9 Baltin	nore,	Maryland
DOCE.	21. Signature of Funeral Service Li	a. Wel	res CF	SP 33	Name and Address VIO J. 1	ss of Facility Weber Fu	neral Ho reet Bal	mes, P.Z	A. Mary	land 21231
cian lical iner	23a, Par1. Enter the disease, or c shock, or heart failure. List or fmmediete Cause (Final diaease or condition	nly one ceuse on e	ech line.		tuch			rrest,	1	Approximate Interval Between Onset and Death
	resulting in deeth)		Due to (or as a consequence	uence of):				1	mon the
Examiner	Sequentially list conditions,	b		or es e consequ	uence of):			- 111	1/	non rus
dicai E	if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c. CO	Tona	1 44		dises	use_			
Medic	resulting in death) Last	o. pe	. '	eral	vascu	lar di	seuse	_		
should be detached for use as leted by Physician/Mex	Part fl. Other significant condition	t contributing to de	ath but not res	sulting in the up	derlying cause at	ren in Pert I	23h Did	tobacco usa co	ntribute to	the cause of death?
y Phys			attrout not res	outing in the un	denying cause give	en in Ferti.		Yes 2 No		pebly 4 Unknown
Completed by Physician/Me	Diabetes Hyperten	SION			1			an autopsy ormed?	ava	ere autopsy findings allable prior to appletion of cause deeth?
E OS							10	Yes 20 No	10	Yes 2□ No
Be	25. Was case referred to medical examiner?	Hospital:			Desca Ott	or.	eth (Check only			
~ -	1 Yes 2 No 27. Manner of Death 1. Naturel 5 Pending 2 Accident investige	28a. Date of	npatient 2 f Injury h, Dey Year)	28b. Time of Injury	28c. Inju	4 U Nursing	Home 5 Res	dence 6 Oth		()
edical Certification:	2 Accident investige 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Piece	of Injury - At h ig, etc. (Speci	ome, farm, stre fy)	et, factory, office		28f. Location (City or To	Street and Numi wn, Stete)	ber or Rura	l Route Number,
etely fille	29a. Certifier Cortifying (Check only one)	Physician: To the taminer: On the ba	sis of exemine	owledge, deeth etion and/or inv	occurred et the til estigation, in my o	ne, date and place pinion, death occ	e, and due to the urred et the time,	cause(s) and modete end plece,	anner es si and due to	ated. the cause(s)
W We	29b. Signature and title of pertiller	. 1	,	44.4	29c. Licens			29d. Dete signe		
	Stagshane	e Lin	der	MO	1145	3909		October	8, 1	999
	20 Name and address of names of	o completed cause	of deeth (Iter	m 23a) (Type, F	Print)					
	30. Neme and address of person we Stephanie Linder				·					



LARRY HUBBARD

Piease Type or Print in Biack Indelible ink. Assure Ail Copies Are Legible

State of Maryland	/ Department of Health and	Mental Hygiene	1600
	Certificate of Death	Reg. No.	1096
st)	HE PARTS	2. Deta of Death North 7 Day 1999 Year	3. Tima of Death 2217 PM

4b. City, Town, or Location of Death

Physician /Medical **Examiner**

Larry Hubbard, Jr. 4e Facility Nema (If not institution, giva street and number) JOHN HOPKINS HOSPITAL

1. Decedent's Name (First, Middle, La

I.C.U 7. Aga (In yrs. last birthday)

21 Yrs.

10c. City. Town or Location

Baltimore

12 M 2 F

BALTIMORE If Under 24 Hrs. If Under 1 Yaar Months Days Hours

4c. County of Death

Birthplace (State or Foraign
Country)

10d. Inside City Limits

11 Yes 2 No

N/A

8. Data of Birth (Month, Day, Year) Oct 20, 19

Funeral Director

filed within 72 hours after death with the Manyland worle r 28a-f ahow 7 is marked other than "natural", or items 23s or traumstic event, the Medical Essiminar must be Hygiene. Peges 1 and 2 should be f nent of Health end Mental

Director Funeral by Completed Be

214-90-6872 Usuel Rasidance of Decedant 3 Widowed 4 Divorced

10a. Stata 10b. County N/A 10e. Street and Number 912 N. Montford Avenue 11 Marital Status 1 Naver Married 2 Married

5. Social Security Number

12. Wes Decedent Ever in U,S. Armed Forcas? Yas 2 No Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - Amarican Indian, Bleck, White, etc. Specify: Black

1977 Maryland

15. Decedant's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Collega (1-4or 5+) 10

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) Vendor

10f. Zip Code

21205-

16b. Kind of Businass/Industry Stadium

10g. Citizen of What Country?

United States

17. Father's Nama (First, Middla, Last)

Larry Hubbard, Sr.

Deborah Carr

19a. Informant's Name/Reletionship (Type, Print) Deborah Carr (Mother)

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 912 N. Montford Avenue, Baltimore, MD 21205

18. Mothar's Nama (First, Middle, Maiden Sumama)

20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Removel from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cematery, crematory or other place) Voshell Memorial Oct 13 20c. Location - City or Town, State Baltimore, MD 1999

21. Signatura of Funaral Service Licensee -211 alve

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility
Smith & Williams Funeral Home, P.A. Baltimore, MD 2818 East Baltimore Street

Physician /Medical Examiner

burial-transit

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signed by the at d be detached for

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After this certificate

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filled in by

completely

or Attending Physician:

death.

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A

Completed by

Be

Medical Certification: To

The lew requires that the deeth certificate be executed

P.O. Box 68760.

Division of Vital Records,

Mem 27 Identra

= 0 important: If any injury o poce. Department

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Ceuse (Diseesa or injury that initiated events rasulting in death) Last Physician/Medical

tmmediate Causa (Final

disease or condition resulting in death)

Gunshot Wound of the Back of the Head Due to (or as a consequence of)

Due to (or as a consequence of)

Dua to (or as a consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Placa of Death (Check only one)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an eutopsy performed?

1 Xes 2 No

24b. Were autopsy findings availabla prior to completion of cause of death? 1 Yes 2 No

Approximata Intervel Between Onsat and Death

25. Was casa refarred to medical axaminar? Yes 2□ No

27. Menner of Death

1 Naturel

2 Accident

3 ☐ Suicida 4 ☐ Homicide

Hospital: 1 ☐ Inpatiant XXER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 5 Panding invastigation 10-7-99

28b. Tima of Injury 1756 PM

Street

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 28d. Describe how injury occurred

Subject Shot by police
281. Location (Street and Number of Rural Routa Number,
City or Town, Stata) 26gs Blk Burchy St Baltomere, Fel

29e. Certifier (Check only one)

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signatura and titla of eartified

link

29c. License number O.C.M.E

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and place, and due to tha cause(s) and mannar es stated.

29d. Data signed (Month, Day, Year) , 1999 OCT.08

errun 30. Name end addrass of person who completed causa of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 hutem

State Registrar

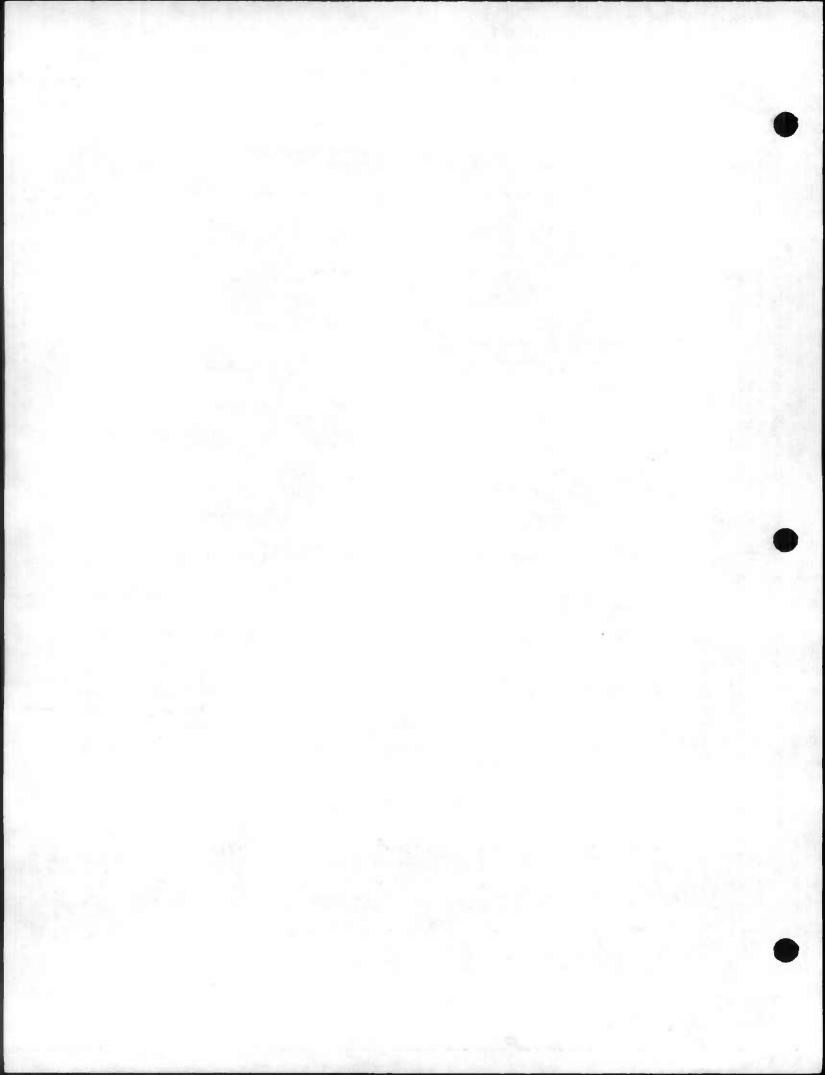
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31. Date filed (Month, Day, Year)

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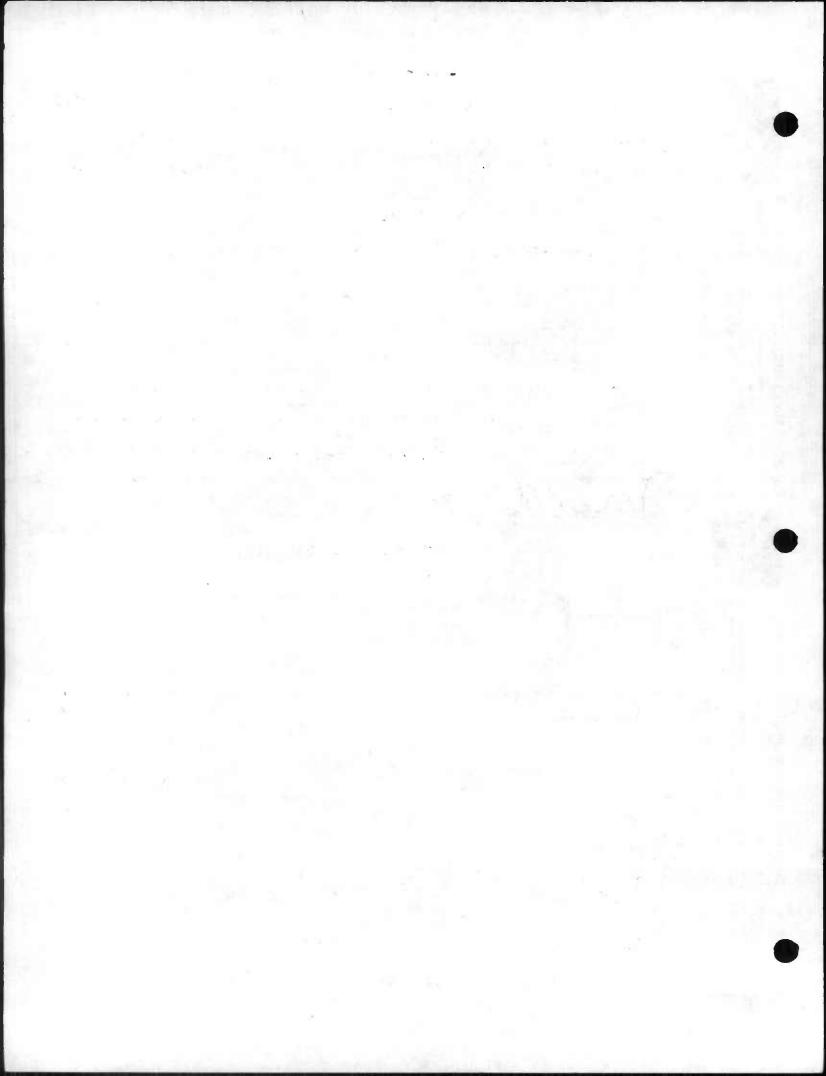
32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 10:25pm Charles Highsmith 99 Oct. 06, /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris @ Mercy Hospice Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 12-23- Birthplace (State or Foreign Country)
 N C **Funeral** Months Days Hours 1 ☑ M 2 ☐ F Director 246-38-0200 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits than "naturel", or itema 23a or 28a-f ahov the Medical Examiner must be notified at MD NA Baltimore MYes 2□No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number flied within 72 hours after deeth with 1314 N. Luzerne Avenue 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Black py 3€Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland High Sch. Grad Supervisor Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health end Mental I int: If Rem 27 is marked of Charles Highsmith, Sr. Rachel Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1304 Luzerne Avenue Baltimore, Maryland Ernestine Sumpter If Item 27 or other t 20b. Place of Disposition (Name of commetery, crematory or other place)
Garrison Forset VA Cem. 10-13-99 Owings Mills, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State permit. Paga Department of Important: If eny injury or paga. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Fecility Baltimore, Maryland 21202 uso WM.C.March FH 1101 E. North Avenue ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Metastatic (te pateng /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): USO BS signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Premonin 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Cuchosis page 2 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attending Physician: director, 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Affer Naturat 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 29b. Signature, and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D40854 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultmer St Paul 21202 Kis ebery 301 Marie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

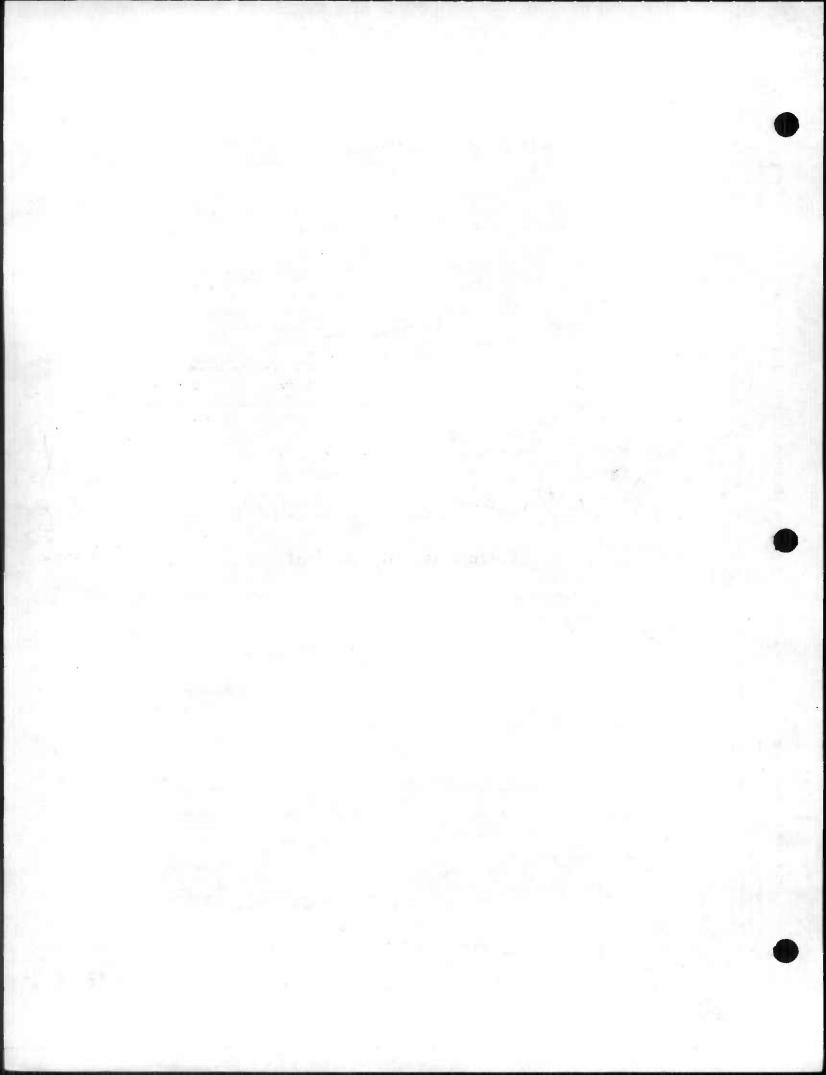


State of Maryland / Department of Health and Mental Hygiene 31694 Certificate of Death 1. Decedent'a Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month
OCTOBER
4c. County of Death
NA Day Physician Harry 1999 Annie /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY HUnder 24 Hrs. 8. Data of Birth HOPKINS JOHNS HOSPITAL If Under 1 Year 7. Aga (In yrs. last birthday) 68 Yrs. 8. Data of Birth (Month, Day Year) 09-08-31 5. Social Sacurity Number 9. Birtholace (State or Foreign **Funeral** Days Months Hours 1□ M 20XF Country) 218-76-2238 Director Usual Residence of Decedant the Merylend 10e State 10b County 10c. City, Town or Location than "natural, or items 23s or 28s-f show the Weddell Examiner rount be notified at 10d. Inside City Limits MD NA Baltimore Director X1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21213 USA 3162 Elmora Avenue Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14 Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to be a superior of Health and Mental Hygiene. Important: If hear 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Exerci-1 Yas 2X No If Yas, Giva Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 VNo Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2nd. Grade NA Never worked Unemployed 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Durant Sammie Lee Harry Mary 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3162 Elmora Avenue Baltimore, MD. 21213 Ellare Nettles 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p. Data 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal term S 4 ☐ Donation 5 ☐ Other (Specify) Kings Mem. Pk.Cem. 10-11-99 Randallstown, MD 22. Nama and Address of Facility 21 Signature of Funeral Service License Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue Part. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heer feiture. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final Cerebrovascular accident disaasa or condition rasulting in daath) week Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be axecuted Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): physician s the burial Box 68760, Physician/Medical Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Preumonia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No funeral director. Be 25. Was case refarred to medicat examinar? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mannar of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 1 Netural 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Cartifiar 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 \$ 29b. Signature and title of certifier. 29c. License number 29d. Data signed (Month, Day, Year) Medical Doctor RES - 000 Oct. 6, 1999 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21287 Melamed 600 North Wolfe Street Michal 31. Data filed (Month, Day, Year) OCT 12 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DETOBER 2:40 P.m MAUDE A. HALFORD 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 05 en runde H Under 24 Hrs 5. Sociel Security Number 7. Age (In yrs. last birthday) H Under Months 1 M ATK MARYLAND 220.28.5957 66 Usual Residence of Decedent 10a Stete 10c. City, Town or Location 10d. Inside City Limits 1 Yes XX No MD ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 179 VIRGINIA LANE 21061 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black White etc Armed Forces/ 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 XX Specify: Specify: WHITE 3 ☐ Widowed 4 X ivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) REAL ESTATE BROKER PROPERTY SALES 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HENRY W. HEBER DOROTHY M. RICE 19e. Informent's Neme/Reletionship (Type, Print) STEPHEN HALFORD - SON 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12385 APT. C, MAVERICK DR., MD HEIGHTS, MO 63043 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State METRO CREMATORY 10/12 BALTIMORE. MD 5 ☐ Other (Specific Juneral Service License 22. Name and Address of Facility FINK FUNERAL HOME. PA Suggery 426 CRAIN HWY., SW., GLEN BURNIE, MD 21061 KELLY GREGORY FINK 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immedies Ceuse (Final diseesa or condition resulting in deeth) atrovic OBSTRUC 14 monossy Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? NO 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760 P.0. Division of Vital Records.

Examiner death certificate be assecuted physician and s the burial-trens bengis be del has this

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

"natural", or flams 23a or

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if Item 27 is marked other th any Injury or other the

Physician

/Medical

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

Medical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

he Hospital or Attending Pin 24 hours after death.

The Funeral Director: After tipletely filled in by the funeral within 2 To the

Registrar

DCT 12

29b. Signeture end title of certifier

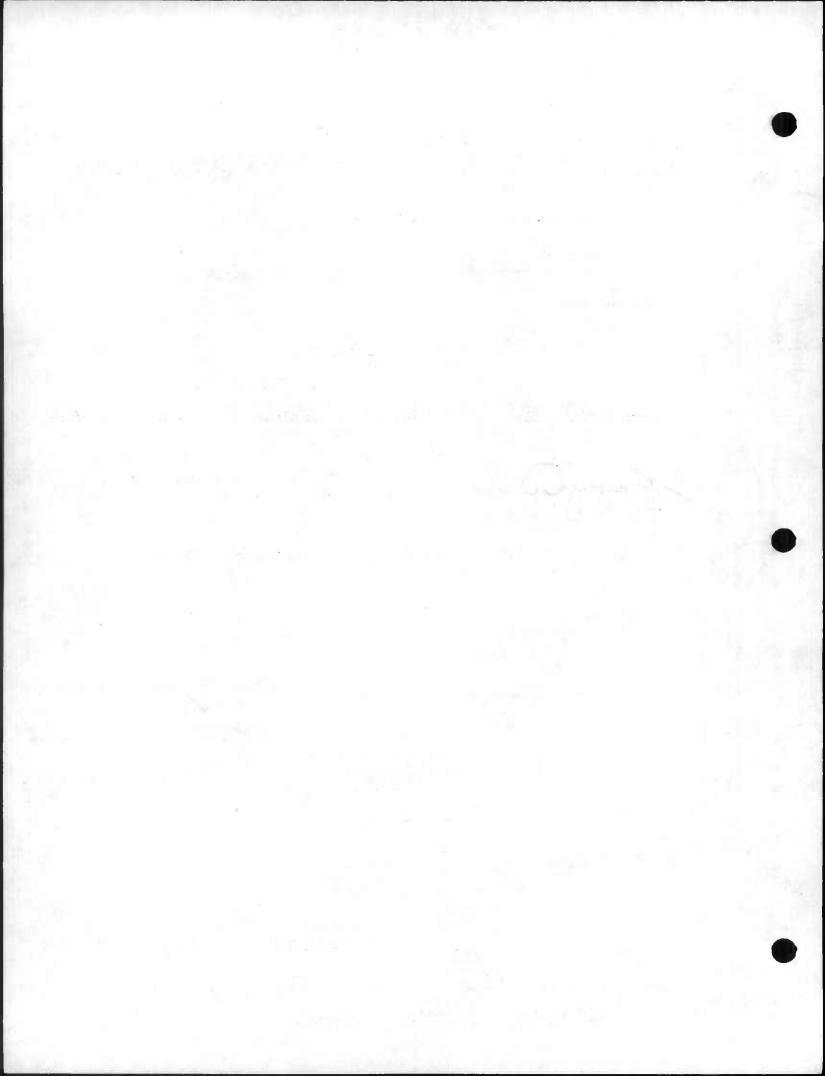
29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29d. Dete signed (Month, Day, Year)

30. Name and addrass of person who completed cause of death (Nem 23a) (Type, Print) re. Mrs. 21061 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 3. Time of Death 1 Decedant's Nama (First Middle Last) 723 Am Frances Marie Holsev 1999 0 0 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Baltimore City Baltimore Agnel Hospita If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Yaar 5. Sociel Sacurity Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) Months Days 1 M 25F 212-30-8529 82 Yrs. June 11, 1917 Maryland Usuel Rasidence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Yes 2□No Maryland Baltimore City Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? United States 1336 Washington Blvd. 21230 12. Was Decedant Ever in U,S. Armed Forcas? Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarlo Rican, etc.) 14. Rece - American Indien, Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Give Year or Datas: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Dacedant's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondery (0-12) Health Care Nurseing Assistant 8 18. Mothar's Nama (First, Middle, Malden Sumame) 17. Fether's Neme (First, Middle, Last) Ella Louise Snyder John Frank Baker 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 8401 Contee Rd. Laurel, MD 20708 Delores Hill/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct. Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ™Surial 2 □ Cramation 3 □ Ramovai from Stata 12, 1999 Glen Burnie, MD 4 Donation 5 Othar (Specify) Glen Haven Mem. Pk. 21. Signature of Funaral Service Licanses 22. Nama and Addrass of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 23a. Part1. Entar tha disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one causa on each line. Approximete Interval Between Onset and Deeth Immediate Causa (Final disaasa or condition rasulting in daath) 9ht- Sided Sequantielly list conditions, if eny, laading to immediate causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Lest Dua to (or as a consequence of): Embolic Thrombotic Due to (or as a consequance of) erosclerosis 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetel 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1□ Yes 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Daeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Hospital: 1 Onpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Dascribe how Injury occurred

Examiner attending physician a for use as the burlaii certificate has b director, page 2 s HOUSE b 25 within 2 To the F

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturel", or itema 23e or i any Injury or other traumatic event, the Mod cal Enauther must be in once.

Physician

/Medical

Physician/Medical Examiner

Completed

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Certification:

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Directo

Funeral

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Completed

with the Maryland

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa referred to medical axaminar? 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Manner et Deeth 28c. Injury at Work? 5 Panding invastigation 1 ANatural 1 ☐ Yas 2 ☐ No 2 Accident

6 Could not be 3 ☐ Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicida

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifian 1 🗹 Cartifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the tima, deta and place, and dua to the cause(s) and manner stated. 29b. Signatura and titla of certifian

Reside

29d. Date signed (Month, Day, Year) 29c. Licansa number 10-09-99

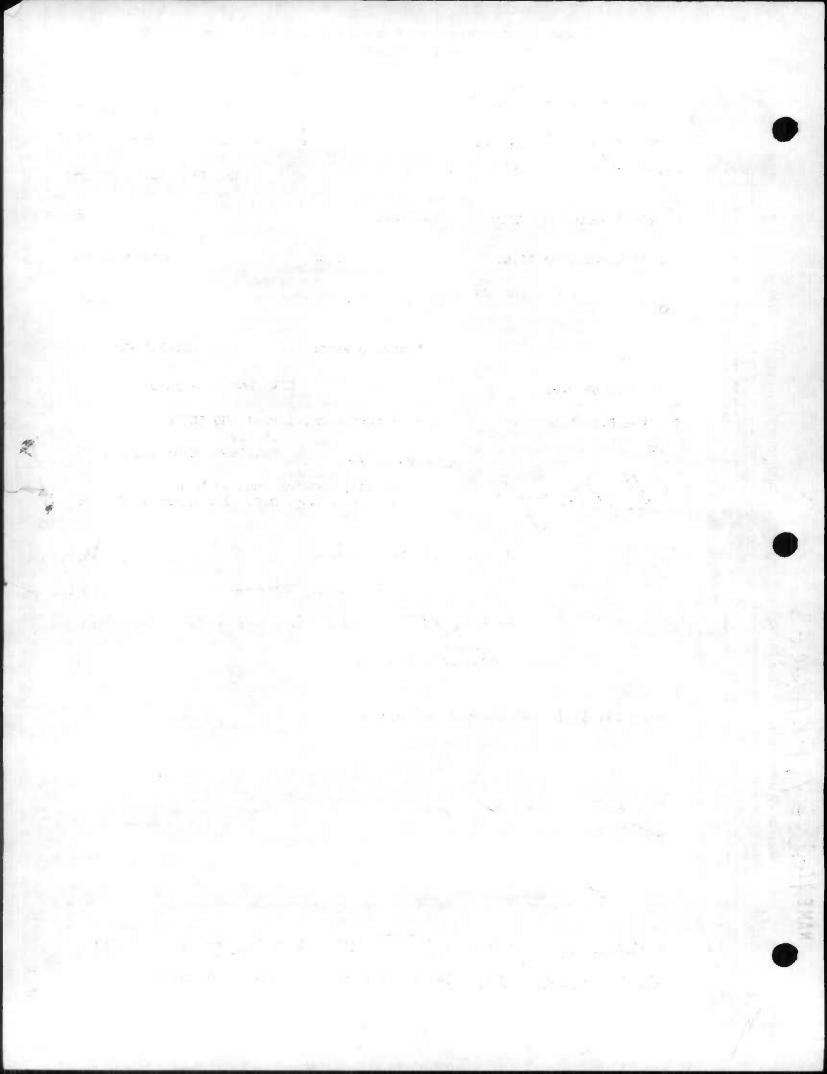
30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print) 900 S Caton Ave Baltimore, MD 21229

State Registrar

31. Data filad (Month, Day, Year)

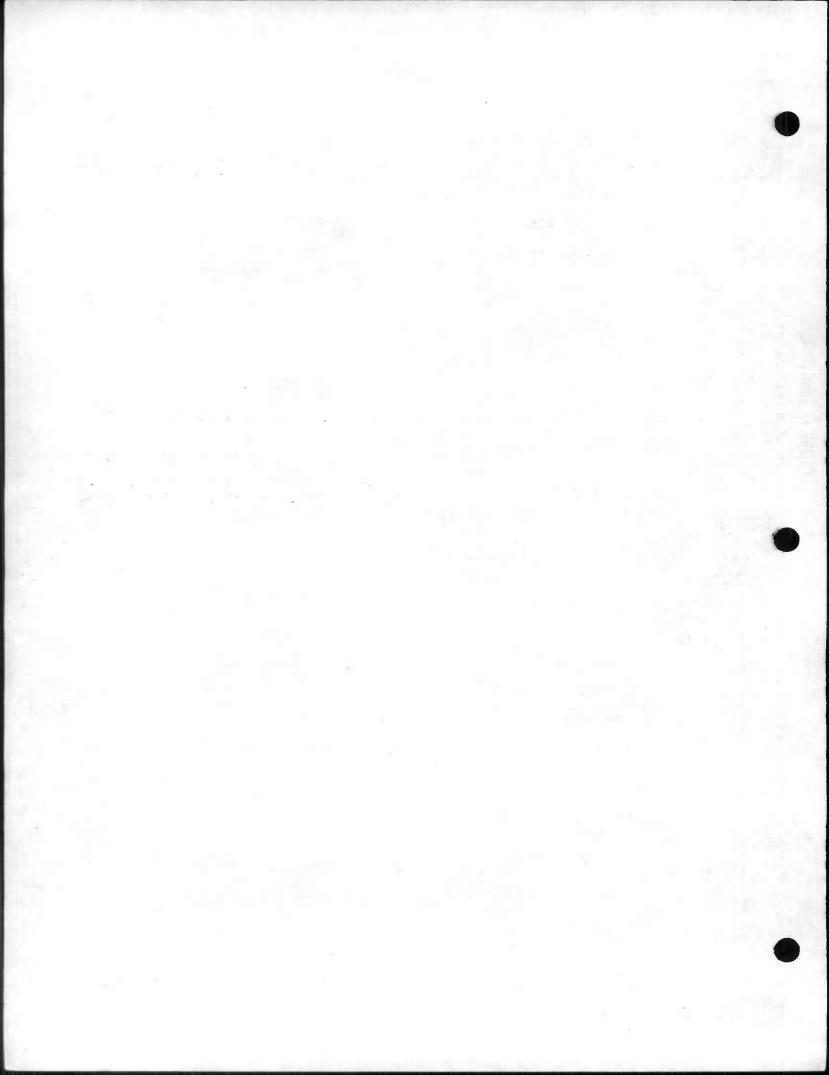
OCT 1 2 1999





State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		leg. No.	0 0 1	001
Physician	Decedant's Nama (First, Middle, La	st) Emily E.	Harper			2. Data of Dea Month	Day		ima of Death
/Medical Examiner	4a Facility Nama (If not institution, giver Franklin Square Ho	a street and number)	r		4b. City, Town, or L.	ocation of Death	4c. County	of Death	
Funeral Director	Social Security Number 6. S	ex 7. Age 85	(In yrs. last birthday,	If Under 1 Year Months Days		8. Data of Birth (Month, Day NOV . 2	Year) 1913	9. Birthplaca (: Country) Pennsy]	State or Fore
show sdat	Usual Rasidance of Decedant 10a. Stata 10b. County	1	10c. City, Town or L	ocation					side City Lim
or 28a-f s be notified Director		altimore			undalk				Yas 2124
ust be notified at rai Director	10e. Street and Number 2510 West Woodw	ell Road		10f. Zip Code	21222	1	Unite	What Country? d States	5
tr. or here tramper m	11. Marital Status 1 □ Navar Married 2 □ Married 3 월 Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yas 2 No If Yes, Give Year or Dates:	ver in U,S. 13.	13. Was Decedent of Hispanic Origin? (Specifit Yes, specify Cuban, Mexican, Puerto Ric			14. Rac Bla Specifi	ce - Amarican Ind ck, Whita, atc. Whit	
went, the Medical Be Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 8 Years	ducation ide completed) College (1-4or 5+)) 1	odent's Usual Occu e kind of work done DO NOT use retire usewife	pation during most of work ad)	sing		usinass/Industry	
	17. Fathar's Nama (First, Middle, Last)				18. Mother's Nam		Maiden Surnan	na)	
tem 27 is marked other other traumatic event, To Be Co	Henry Spotts 19a. Informant's Name/Ralationship (t and Number or Rui)
Ta Ta	Julia Cook /	Daughter		Lomond Ct	. Baltim	ore, Mai	•	21237	
= 5	20a. Mathod of Disposition 13☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 2)			osition (Name or Imatory or other pla In Cemete		/1999		City or Town, Si more, Ma	
Department Important: I any injury o once.	21. Signature of Funaral Service Loar	asee			ass of Fecility Funeral Ave. Du				2
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attending physician and dor use as the bunk-transit clan/Medical Examiner	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or injury that initiated events rasulting in death) Last	C	ue to (or as a consec						
the att hed for	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	anderlying cause gi	iven in Part I.	23b. Did to	obacco use co	ntribute to the o	ause of de
been signed by the attendin should be detached for use leted by Physician/N	ATRIAL FL	BRILLA	ATION,	C HROI	vic		res 2□ No	3 Probably	4 Unkr
arificate has been signed by the attendin ctor, page 2 should be detached for use Be Completed by Physician/N	OBSTRUCTION P URNTRICULAR	ULMONARY TACHYE	OISRASR, ARDIA	COPGEST	TUR HEAD	7 24a. Was a perfor	in autopsy med?	24b. Wara au available completi of daath	prior to on of causa
icate r. pag	FAILURE, PERIPH	BRAL VASC	CULAR DI	SRASR		1 U Y	- /	1 ☐ Yas	2□ No
s certification	25. Was casa referred to medical axaminar? 1 ☐ Yas 2 📜 No	Hospital:	2 ER/Outpatie	ot 3 DOA Ot	26. Placa of Deal	th <i>(Check</i> on <i>ty</i> or oma 5 ☐ Resid		nar (Snacihi)	
After this funeral of	27. Mannar of Death 1 Natural 5 Pending 2 Accident invastigation	28a. Date of Injury (Month, Day)		of 28c. Inju		28d. Describe h			
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicida 6 Could not be determined		y - At home, farm, st (Specify)			28f. Location (S City or Town	treet and Numb n, State)	ber or Rural Rout	e Number,
Ethour Funeral letely fills	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of a niner: On the basis of a and manner state	xamination and/or in	h occurred at the ti vestigation, in my	ime, data and place, opinion, daath occur	and dua to tha c red at tha tima, d	ausa(s) and ma lata and place,	anner as stated. and dua to tha c	ause(s)
C Z O M	29b. Signatura and title of Artifiar	m		29c. Licen	se number	2	29d. Data signe	d (Month, Day,)	'ear)
To the		///		1			- 0	0.0	
within To the comp	30. Nama and address of person who	14	th (ltor (22a) (Time		nklin Square		10-9	•	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth Month **Physician** Dotober 9:45 A.M Susan Marie Hannigan /Medical 4e. Fecility Neme (If not institution, give streat end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** North Arundel Hospital Glen Burnie Anne Arundel Hours Min. 8. Date of Birth (Month, Dey, 5/2/72 5. Social Sacurity Number If Under 1 Year 7. Aga (In yrs. last birthday) Birthplece (Stete or Foreign Country) **Funeral** Days 1 □ M 2 1 2 F Yrs. Director 217-86-7580 27 Md Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Md. Anne Arundel Director Pasadena 1 ☐ Yes 2 TNNo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? 635 Cyril Ave. 21122 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Ricen, etc.) Race - Americen Indien, Black, White, atc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Asst. Manager 12th Retail Store 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be James T. Lonczynski Dolores L. Ocasek 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) James T. Lonczynski/father 115 Cloverhill Rd. Sunset Beach Md. 21122 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 10/11 Balto., Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. rameroushe 4001 Ritchie Hwy. Baltimore, Md. itions thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, cause on each line. 21225 Approximate Intervel Between Onsat and Deeth Physician Immediata Ceuse (Final CANCER. disaese or condition resulting in death) Due to (or es e consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thef initiated events resulting in deeth) Lest Due to (or es a consequence of): Physician/Medical Due to (or es e consequance of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to complation of ceuse of death? Completed 24a. Wes en eutopsy performed' 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical axaminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 2 1 Yes 2 No Inpatient 2 ER/Outpafient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could nof ba determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, straef, factory, office building, etc. (Specify) 4 D Homicide Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of exeminetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end manner steted. 29a. Certifier cai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M 30 Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Horrital John les. 301 Registrar Signature

Registrar

28a-f show must be notified at

b items 23a

8

'natural'

Hygiene.

marked other

Important: If Item 27 is any injury or other trau

/Medical

Examiner

physicien and s the buriel-tran

signed b

page 2 s hes

director,

certificate

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After

death. efter death Director: A d in by the f

To the Hospital within 24 hours a To the Funeral D completely filled in a completely filled

98

requires that the death certificate be executed

The law

the Hospital or Attending

Box 68760

P.O.

Records,

of Vital

Division

Health and Mental

Department of

Pages 1 and 2 should

Baltimore, Maryland 21215-002(

US AN

the Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryl

If Under 1 Yaar Months Days

and /	Department	of Health and	Mental Hygier
		4	

If Undar 24 Hrs. Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 23,1965

3. Time of Death

Birthplaca (State or Foreign Country)

21090

Urrace

OCT.

29d. Data signed (Month, Day, Year)

, 1999

10d. Inside City Limits

Maryland

6:13 PM

EDWARD HORSEMAN Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month **Physician** 6', 1999 Edward Michael Horseman OCT. /Medical 4a Facility Name (If not institution, give street and number)
UNIVERSITY HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

7. Age (In yrs. last birthday)

10c. City, Town or Location

33

Funeral Director 5. Social Security Number

213-92-5823

10a State

Usual Residence of Decedent

10b. County

6. Sex

1⊠ M 2□ F

Items 23s or 28s-f show "natural", or

Pages 1 and 2 should be filled within 72 hours after death with the Manyland ment of Health and Mental Hyglene.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed physician the burial Division of Vital Records, P.O. Box 68760, USB After this Medical Certification: within 24 hours after deat To the Funeral Director: completely filled in by

Maryland Anne Ar	undel l	Lithi	cum				1 ☐ Yas 2 🖾 No	
10e. Street and Number			10f. Zip Code		10g. C	itizen of W	/hat Country?	
1221 Furnace Roa	d			21090	U	nited	l States	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Datas:	J,S.	13. Was Decedent of I II Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto F	cify Yes or No- lican, etc.)		aca - American Indian, lack, White, etc.	
15. Decedent's Ed (Specify only highest gra	ducation de completed)	11	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	Kind of Bu	siness/Industry			
Elementary/Secondary (0-12)	College (1-4or 5+)		aoke	0)	E	ntert	ainment	
17. Father's Name (First, Middle, Last) David L. Horsem					(First, Middle, Meide		Θ)	
19a. Informant's Name/Reletionship (Type, Print)		Meiling Address (Street				Stete, Zip Code)	
Melinda L. Horsem	an (Wife)	122	l Furnace	Road Lithi	cum, MD 2	1090		
20a. Method of Disposition 1 ☐ Burlal 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	cemetery,	isposition (Name of cremetory or other ple Crematory		Date 20c. t		City or Town, State	
21. Signature of Funeral Service Licer	Su nices	i d		uneral Homonds Ferry			ne, MD 21227	
disease or condition resulting in death)	b		nsequence of):	0 300,00				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c		nsequenca ol):					
resulting in death) Last	Dua to (c	or as a cor	nsequence of):					
Date Out and a large							1	
Part II. Other algnificant conditions of	ontributing to death but not res	suiting in ti	ne underlying cause gr	ven in Part I.		2 No	atribute to the cause of death?	
					24a. Was an autoperformed?	opsy	24b. Were eutopsy findings available prior to completion of causa of deeth?	
					Yes :	2 No	1 Yes 2□ No	
25. Was case referred to medical examiner? XXX Yes 2 □ No	Hospitali Inpatient 2	ER/Outp	atient 3 DOA Ott	26. Place of Death	(Check only one)	6 Oth	ar (Snecify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicida 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ne of 28c. Inju	y at rk? Yes 200 No	8d Describe how inj	F 81		

State Registrar

DHMH 16 Rev 6/95

29e. Cartifie

29b. Sign

30. Name

one)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

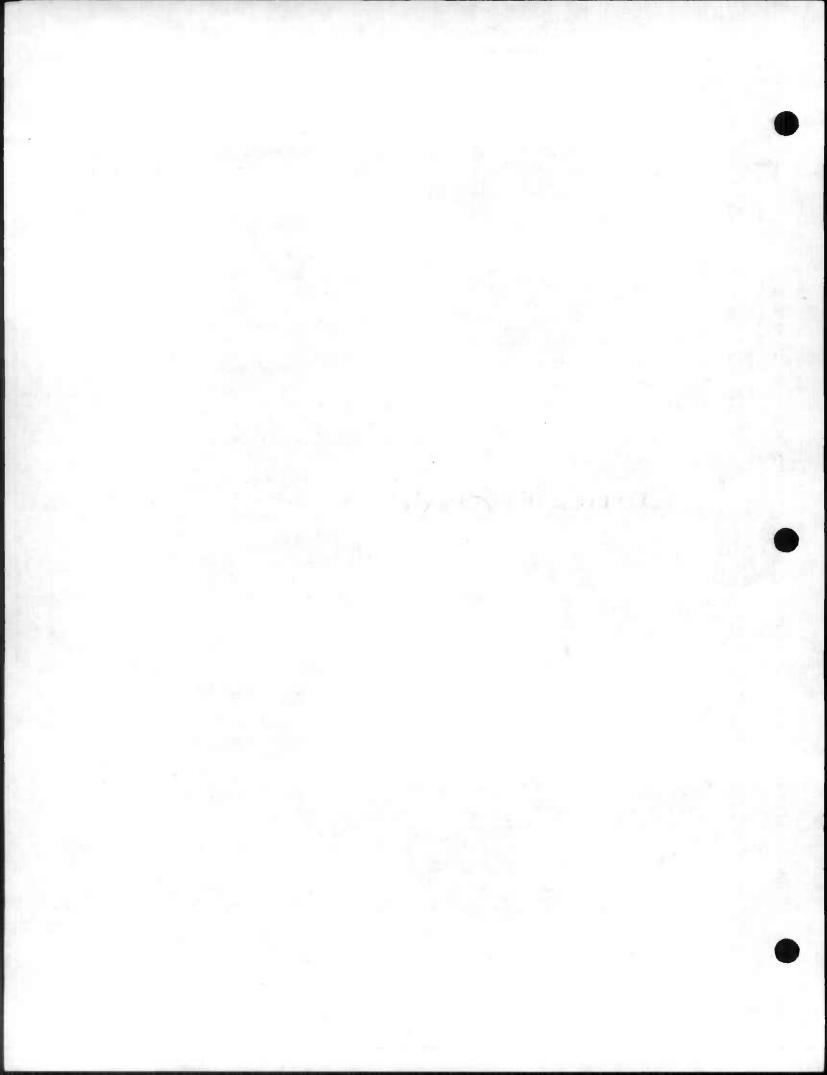
111 Penn Street, Baltimore, Maryland 21201

Home

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E



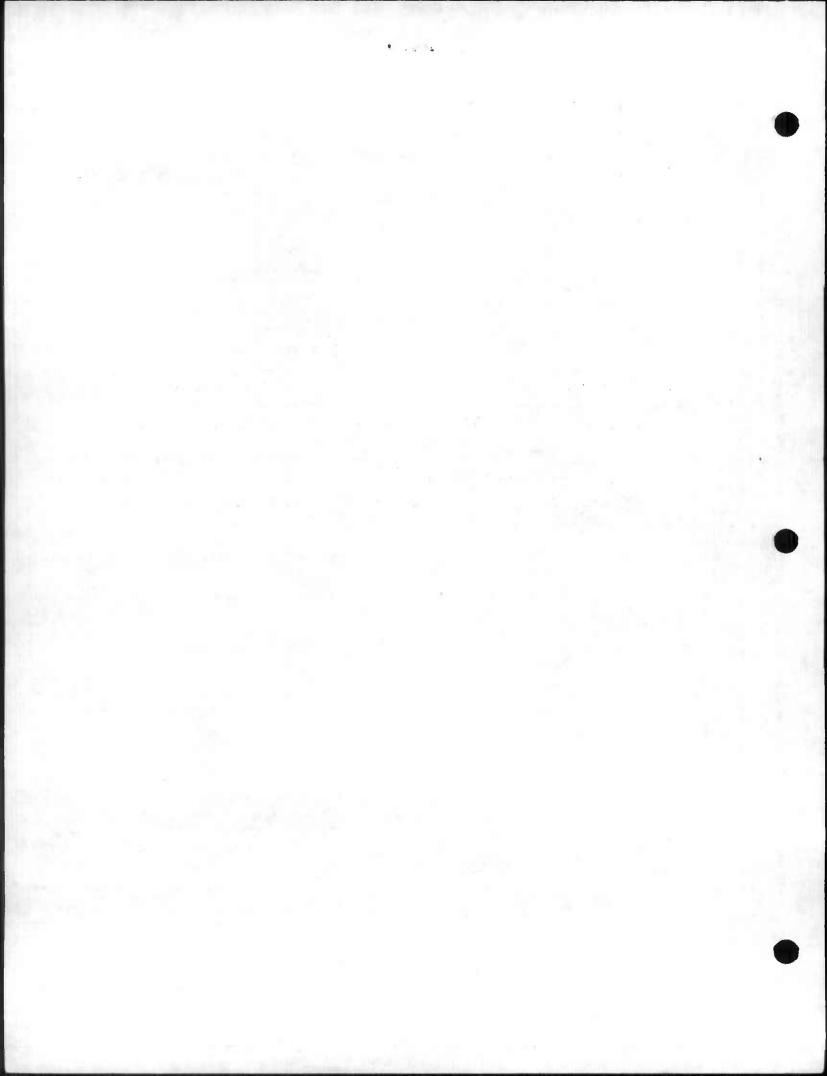
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** John Edmund Hergenroeder, Jr. Oct. 10, 1999 4:36 a.m. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore N/A Hours Min. 8. Date of Birth (Month, Dey, Year) 6. Sex 1Ø M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 215-05-1378 90 Maryland Director Oct. 28, 1908 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. 1 Yes 2 No Directo 288-7 Maryland N/A Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 4905 Belair Road 21206 United States Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: natural, or þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) 8 VYS. College (1-4or 5+) Self Employed Bakery yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; if Nem 27 is marked of John E. Hegenroeder, Sr. Uberlacher Barbara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy C. Hergenroeder / Wife 4905 Belair Road Baltimore, Maryland 20a. Method of Disposition

1 2 Burlat 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 10/13/99 Baltimore, Maryland 21. Signature of Funeral Service Licensee Gary R. DiGiovanni 22. Name and Address of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Light only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 30 min ION MICHAR PARMITIMES disease or condition resulting in death) Examiner OUNINAY O YNS attending physician and for use as the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vitai I or Attending Physician: after death. Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 8 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 28a. Date of tnjury (Month, Day Year) assurance 1 Naturat 5 Pending investigation 1 Yes 2 No 10-10-27 28f. Location (Street and Number or Rural Route Number, City or Town, State) puccs7 2 Accident 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify), 4 Homicide Home 4705 BERMERD GATO, MA Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 20390 will 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOLLON UP. BAJO. M.S. 21236 CHARCOS HUESCH 31. Date filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

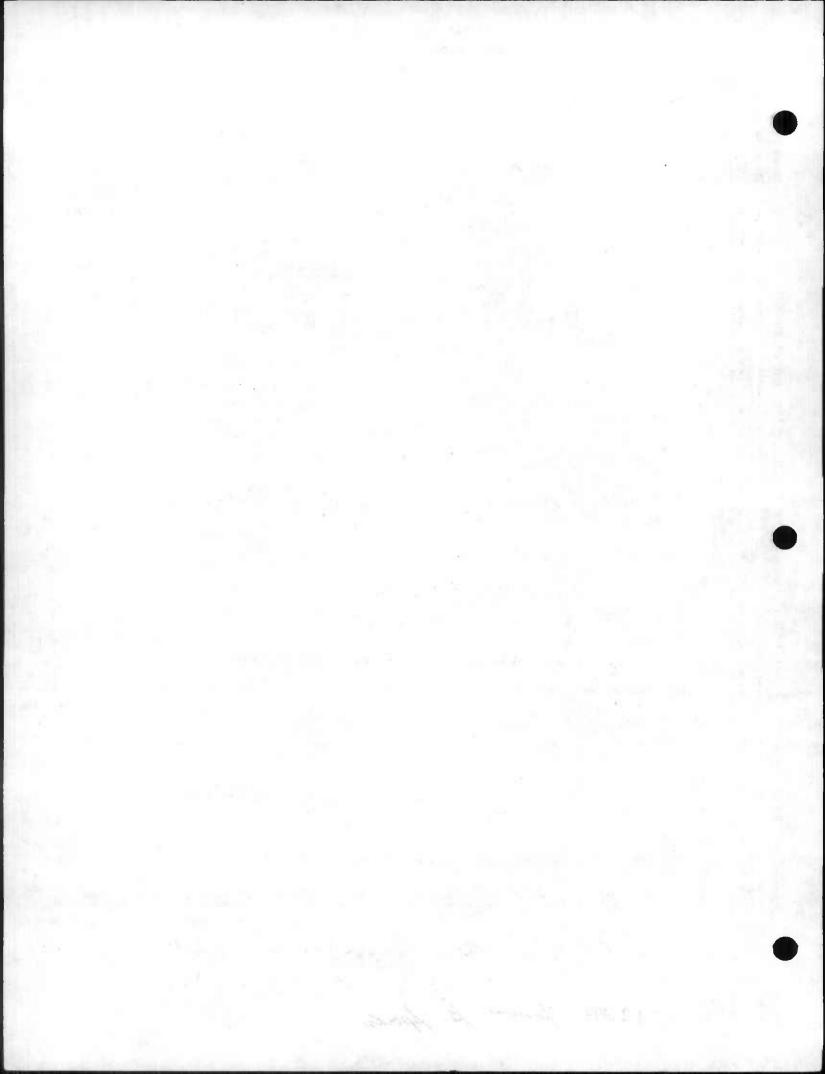
OCT 12



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedeni's Nama (First, Middla, Last) Day **Physician** 1999 Mary Hollis 7:42 AM 2cto be 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital isaltimore Baltimore City OF If Under 1 Year | If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) 02/10/1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KF Months 408-36-7146 69 Director Arkansas Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD N/A Funeral Director BALTIMORE 28a-4 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1705 LAKESIDE AVE 21218 USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or itsems 11 Marital Stalus 12. Was Decedent Ever in U,S. Armed Forcas? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If them 27 is marked other than "netural", or its 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK Specify p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5 + Elementary/Secondary (0-12) SCHOOL TEACHER EDUCATION 17. Falhar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be ROBERT WILLIAMS ROSETTA WEATHERSBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if them 27 is or other tra BRUCE BUNYAN (SON 10203 FLEMING AVE. BETHESDA, MD. 20814. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from Stata Department of Important: If any injury or DRUID RIDGE CEM. 10/11/99 PIKESVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensae 22. Nama and Addrass of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212 illiam an TH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final day S disease or condition resulting in death) Examiner Examiner burial-transit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury thal initiated events resulting in death) Last and Due to (or as a consequence of). ulopa Box 68760, Physician/Medicai the USB as 1 ate has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 Yes 1 Yes 2 No certificate funeral director. Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medicai completaly (Check only one) e da 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 0 RESOUC MO person who completed cause of death (Item 23a) (Type, Print) Schlosse Hospital of Bullimore MM nae. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 2 1999 Registrar

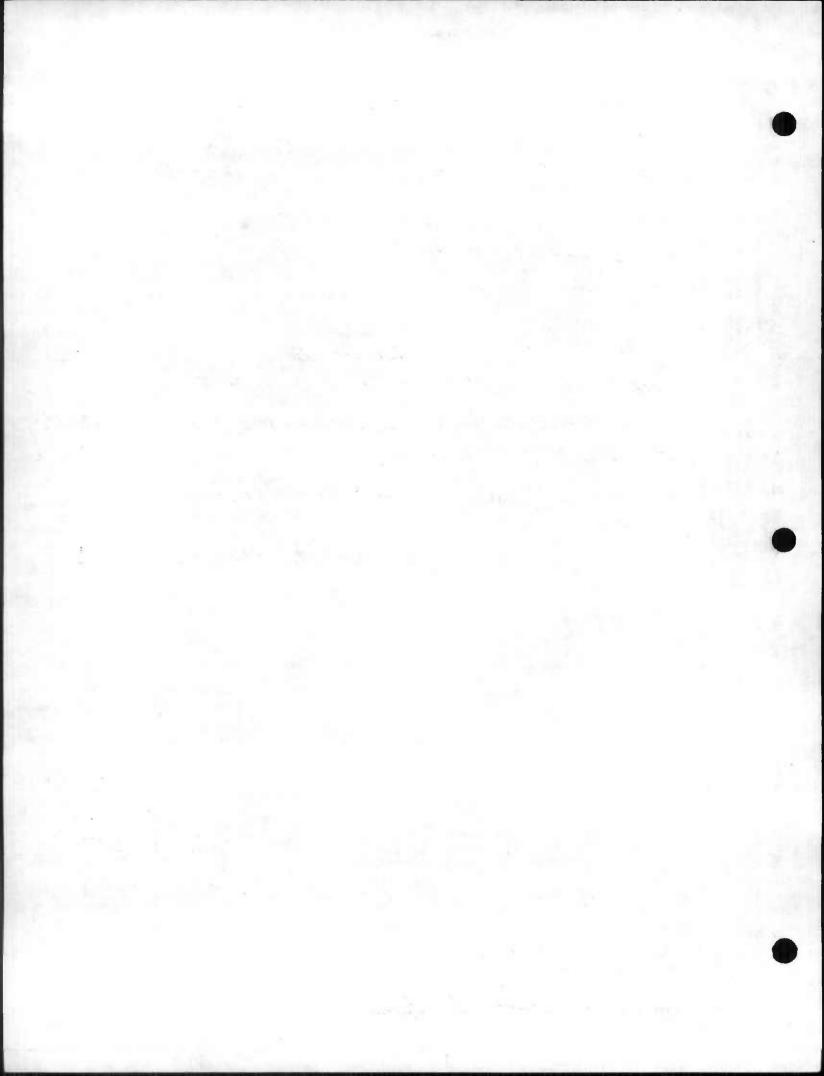


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State of Maryland / Department of Health and Mental Hygiene

		Certific	cate of Death	Reg. N	to. 99 (31702
Dhusisian	Decedent's Nama (First, Middle, Last)	212111		2. Data of Death	Day Year	3. Time of Death
Physician /Medical	KENDALL	HAWKS		OCTOBER (04, 1999	3:20 PM.
Examiner	4a Facility Name (If not Institution, giva street and number)		4b. City, Town, or L		Ic. County of Death	
	4700 WINDSOR MILL RD. 5. Social Security Number 6. Sax 7. Age	e (In yrs. last birthday) If U	BALT nder 1 Year If Under 24 Hrs.	IMORE 8. Date of Birth	O Dist	(0)
neral ector	214-96-9130 12M 2 F	18 Yrs. Mor		(Month, Day, Yes	Soun Coun	lace (State or Foreign try)
H	10a. State 10b. County	10c. City, Town or Location			1	Od. Inside City Limits
utlad	MD	BALT	MORE			1 XYas 2 No
at be notified al Director	10e. Street and Number 4302 WoodLEA		21206	10g. C	Citizen of What Coun	try?
by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ Mile Yes, Giva Year or Dates:	10	ecedent of Hispanic Origin? (Si specify Cuban, Mexican, Puerto es 2 Ano Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - America Black, Whita, Specify: 232	atc.
pet	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's	Usual Occupation If work done during most of work	16b.	Kind of Business/Inc	lustry
Completed	Elemantary/Secondary (0-12) Collega (1-4or 5	'life DO NO	OT use retired)	F	URNITU	RE
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To Be	17. Father's Name (First, Middla, Last) WHAR THAN 17	HAWKS	DOM/	a (First, Middle, Maid XA E	BLACK	
/	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	Irass (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip	Code)
	DONNA BLACIZ (MOTH	(ER) 4302 (Dood LEA M	E BALTO	M/Q 3	21206
	20a. Method of Disposition 1 Ø Surial 2 □ Cremation 3 □ Ramoval from State	20b. Place of Disposition cemetery, crematory	or other place)	Date 200.	Location - City or To	wn, Stata
	4 Donation 5 Other (Specify)	MI 210	N !	0-11-41/1	405 DO LOE	- wiel
BUCB	21. Signature of Furteral Service Licensee	O ALE	BALLIMOR	60021B	ERTY H	111/5
	23a. Part 1. Enter the disease, or complications that caused	tha death. Do not enter the	mode of dying, such as cardiac	or respiratory arrest,	2/20	Approximata
,	shock, or heart failure. List only one cause on each tin		. (1	Interval Between Onset and Death
i	Immediate Cause (Final disease or condition	Itale U	unchot V	Vounds		
Luc-	rasulting in death)	Due to (orlas a consequence	of):			
Examiner	b					
Exar	Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury c.	Dua to (or as a consequence	of):			
		Due to fee as a sense was	-0.			
edical	resulting in death) Last	Dua to (or as a consequence	OF):		t	
NZ.	d					
sicia	Part II. Other algorificant conditions contributing to death bu	ut not resulting in the underly	ing causa given in Part I.	23b. Did tobacc	co use contribute to	the cause of death?
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Completed				Yes	2 No DE	Îves 2□No
BeC	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only ona)		
To	1 No Hospital: 1 Inpatier	nt 2 ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 Residence	6 X Nother (Specify	IN IN
	27. Manner of Death 1 ☐Natural 5 ☐ Pending (Month, Day	Year) Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	WOODS
catl	2 Accident Investigation		1 Yes 2 No	Subje	et 8he	
Certification:	detarmined 28e. Place of Inju building, etc		ctory, office	28f. Location (Street City or Town, Sta	and Number or Rura	Route Number,
ပိ		Woods		4700 M	rusok!	11/20
edical	29a. Cartifier 1☐ Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or investiga	rred at the time, date and place, ition, in my opinion, death occur	and dua to tha cause red at tha time, data a	(s) and manner as si and place, and dua to	ated. tha cause(s)
₩ 2	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month,	Day, Year)
	Jan Loud)	O.C.M.E.		OBER 05,	-
	20 Name and address of passes who	noth (Hom 00-) (T D ' '				
	30. Name and addrass of person who completed cause of de		treet, Baltimo	re. Marvla	nd 21201	
	31 Date filed (Month, Day Year) 32 Pecietre	TIT I CHILL	LLCCC, DULLINO.	ce, rancy and	M ZIZVI	

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item 2 per MD g776 10/15/99 AH AMEND ITEM: #7 PER MD G776 10-14-99 WR. Certificate of Death 2. Dete of Deeth 10/7/99
Month Dey Year
SEPTEMBER 7 1999 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Physician CHARLES HOLUPKA 11:05 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Baltimore City Baltimore Mayland JUHNS HOPKINS BAYVIEW MEDICAL CENTER 6. Sex. 15 M 2□ F If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) **Funeral** Deys Hours 73 Yrs. 175241266 15 1925 PA Director Usual Residence of Decedent the Maryland 10e. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothled at 1 ☐ Yes 2 ☐ No Directo MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7041 Dunhill Rd. 21222 USA deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after Department of Health end Mental Hygiena. Important: if item 27 is marked other than "natural", or ite Y Yes 2 NoWWII
Yes, Give
Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 White à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dispatcher Trucking 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumer Steve Holupka Mary(Yuhas) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Holupka/ Wife 7041 Dunhill Rd. Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Injury or Armagh Cemetery 10-10-99 Armagh. Pa. 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Bny Bradley-Ashton-Matthews Funeral Home Inc. K. Marshal 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

2134 Willow Spring Rd. Baltimore, Md 21222

Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) ASPIRATION PNEUMONIA Examiner Due to (or as a consequence of): Examiner HYDROCEPHALOUS YEAR NORMAL PRESSURE buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): pue physician certificate be Physician/Medical that initieted events resulting in deeth) Lest Due to (or es e consequence of) the 60 950 23b. Did tobacco usa contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. à 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed hes 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b Time of 28c. Injury et Work? Certification: Naturel 5 Pending Investigation after deeth.

Director: Aft
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide n 24 hou. Funeral F Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner as stated.

— Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29e. Certifier (Check only one) To the Vithin 2 29d. Date signed (Month, Dey, Year) OCTOBER 7, 1999 September 7, (99) 29b. Signeture end title of certifier 29c. License number xauawe RES-000 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Johns Hopking Hospital Tower 110 Baltimore, Maryland

32. Registrer's Signeture

1999

AHIS

DHMH 16 Rev 6/95

State

Registrar

CHARLETTER

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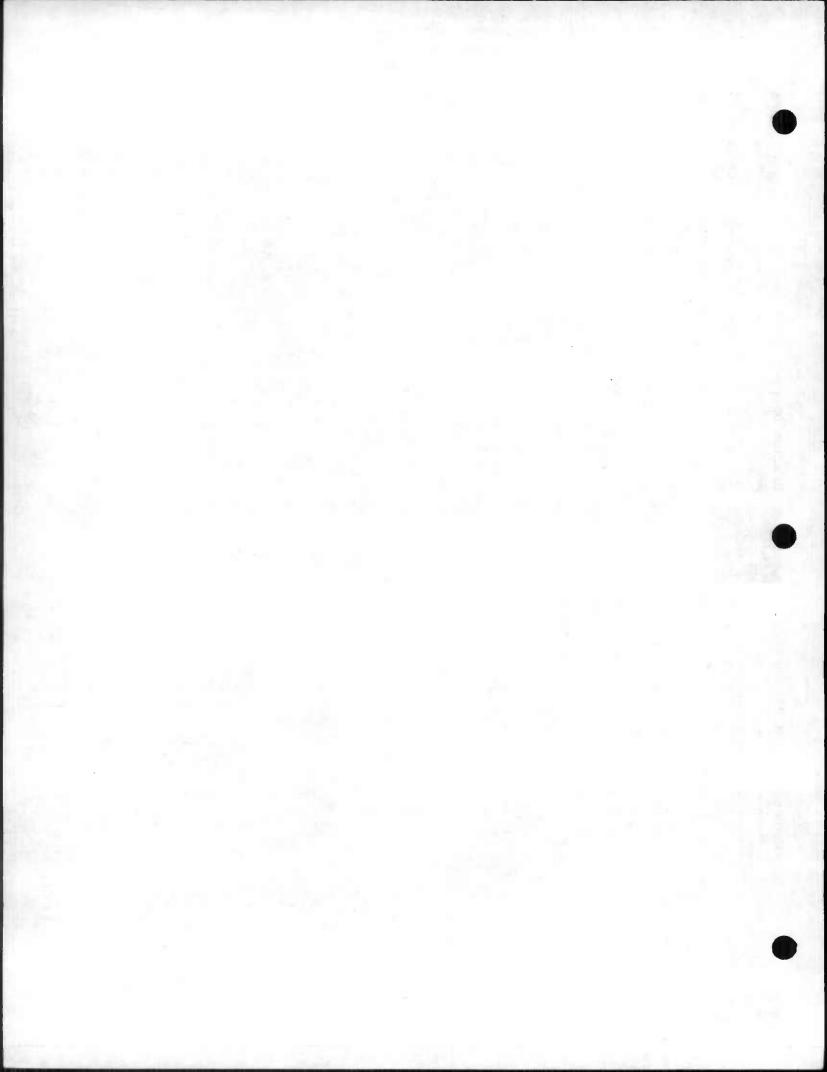
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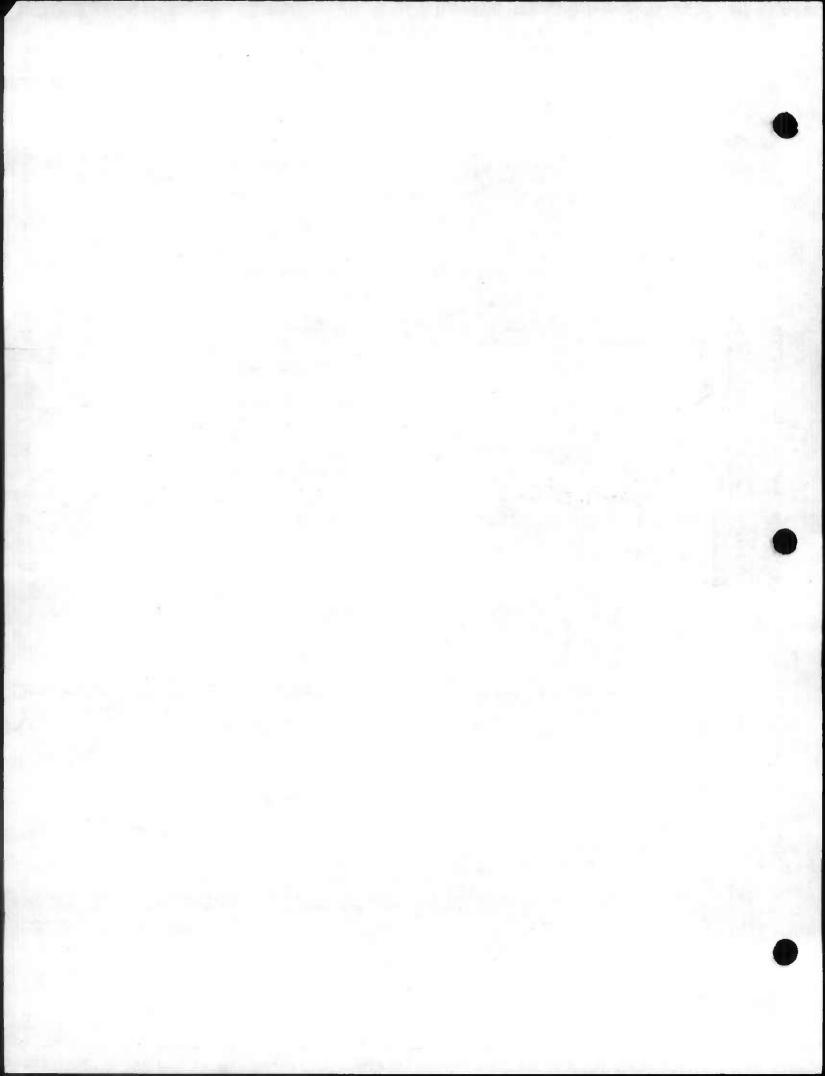
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			Johns Hopkins Hospital		hirthrlay) If Under 1 Yes	Baltimo		N/A		
	Funeral Director		5. Social Security Number 1/8-42-5632 G. Sex 1□ M 2⊠ F Usual Residence of Decedent	7. Age (In yrs. last t	Yrs. Months Day			v. Year)		ace (State or Foreign ry) 2 1/ LANO
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	de de	Funeral	11. Marital Status 12. Was Do	ecedent Ever in U,S. Forces?	13. Wes Decedent o	Hispanic Origin? (Specify Yes or No-	14. Rac	e - America k, Whita, e	
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Baitimore,	permit. Pages Department of Important: If It any Injury or o		21. Signature of Futeral Service Licensee	~	22. Nama and Add	dress of Facility	00000	JR.F	UNE	RAL Home
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	0 0 2	Physician/	Part II. Other significant conditions contributing to	death but not resulting	in the underlying causa	given in Part I.	23b. Did t	obecco use co	ntribute to	the cause of death?
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	W,		30. Name and address of person who completed ca	use of death (Item 23a		Gt	-742	M		1201
	W	10	31. Data filed (Month, Day, Year) 32.	Registrar's Signatura	111 Penn	street, B	attimore	, maryla	ina 2.	TZUI
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ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelth and Mental Hygiens. If them 27 is marked other than "natural", or them 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Merital Stetu	nerokee Cin s larried 2 Merried d 4 Divorced	12. Wes Decedent Armed Forces?	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No			lispanic Origin? (: an, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	lo- 14. F	State - American Stack, White, city: Wh	can Indian,	
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and a			Disposition 2 ☐ Cremation 3 🔀 on 5 ☐ Other (Specify		ary, cremetory of	Disposition (Name of y, cremetory or other place) kland Crematory		Data 20c. Location - City or To 10-7-99 Hartwell, Ge				
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State Registrar

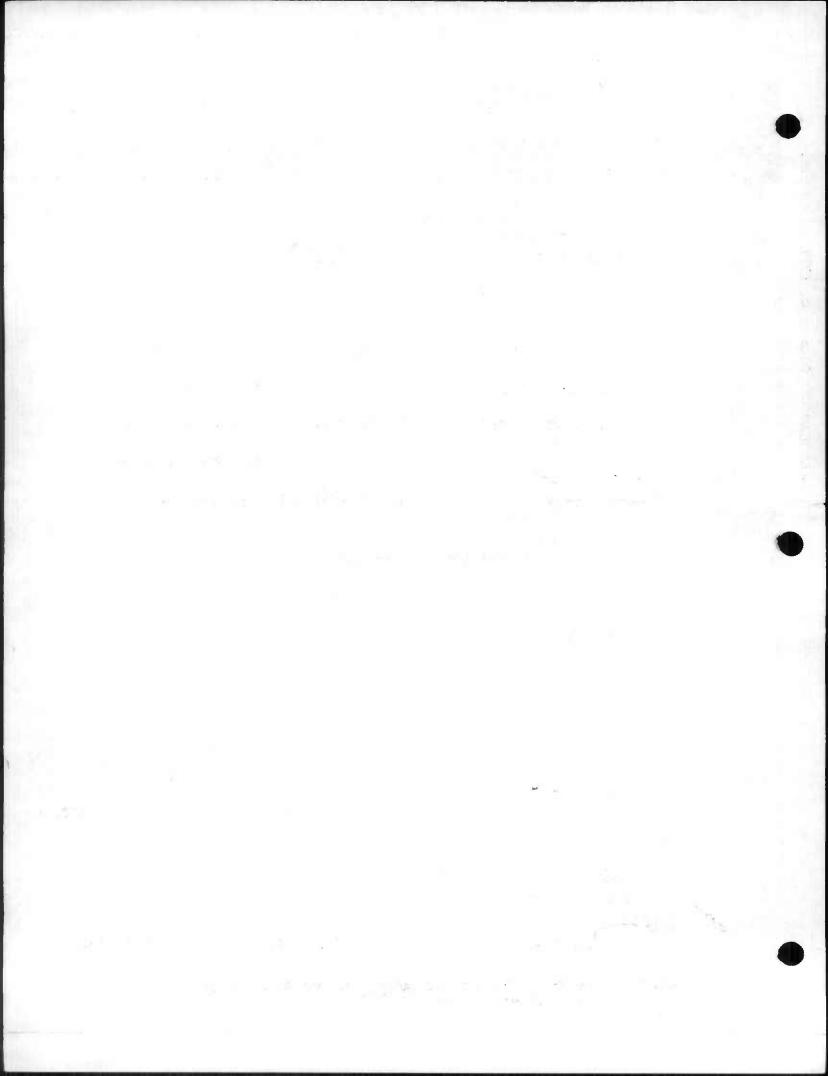


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State of Maryland / Department of Health and Mental Hygiene 99

31706

							Ce	rtificat	e of	Death		F	Reg. No.		01	100
			1. Decedent's Name (First, I	fiddle, Last)							2. Dete of Dee	eth		3. Tir	ne of Death
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Fune	oral		5. Social Security Number	6. Se		Age (In yrs.	last birthday	# Unde	1 Yea			ALLEY 8. Dete of Birtl		FIMORI		ate or Foreign
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CZNI	-		LAWRENCE W.	HEDRI (CK / HUS	BAND	2	O HON	EYC	OMB RO	AD	BALTIMO	RE, MD	2122	0	
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or Attended free deal	eu ka u pa	ertification:	3 ☐ Suicide 6 ☐ Co	estigation uld not be termined	28e. Pleca of li building, e	njury - At h etc. <i>(Speci</i> i						28f. Location (S City or Tow	treet end Num n, Stete)	ber or Rure	el Route	Number,
4 hours	Sietery Tille	edical C	29a. Certifier 1 Certifier (Check only one) 1 Med	fying Physical Examin	elclan: To the bes ner: On the basis end menner s	of exemine	owledge, deet etion end/or in	h occurred vestigetion	et the t	time, date en oplnion, dee	d place, th occurr	end due to the cred at the time, o	euse(s) end m lete end plece	enner es s , end due to	teted.	use(s)
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			30. Neme end eddress of per													
	Stat	0	DR. TARIO M	ADMOU P4 ⁽⁾		DULAN	EY VAL	all	D.	TIMO	NIUM,	MD 210	193			-



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** Cecelia R. Hanke October 7, 1999 6:25 pm /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore Hours Min. S. Dete of Birth (Month, Pay, Year)
June 9, 1922 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🛛 F 213 14 8579 77 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 28a-f show Maryland | Baltimore Essex 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 803 Brunswick Rd. 21221 USA herns 23s 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (ŽNo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 'natural', or 1 Yes 2 No Specify: Specify: White þ 3 DWidowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Other then "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home nemit. Pages 1 and 2 should be filed began to the selfs and Mental Hygi reportant: If Item 27 is marked other my Injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Bernard Gardiner Mary Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addreas (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cecelia Louise Hanke (Daughter) 803 Brunswick Rd. Baltimore, Md. 21221 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of Jesus 10/11/1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) m of Funeral Service Licenses 22. Name end Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) months concer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a that the death certificate be exe Box 68760. Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? Records, P.O. 12 Yes 2 No 3 Probably 4 Unknown ģ 24a. Wes an eutopsy performed? 24b. Were eutopsy findinga evailable prior to completion of cause of death? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medicat axaminer? 89 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 405pc 1 ☐ Yes 2 ☑ No Certification: To 曹 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After Division Attending 1 Matural 5 Pending death. 1 Yes 2 No investigation n 24 hours after death as Funeral Director; J pletsky filled in by the I 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ò 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated.

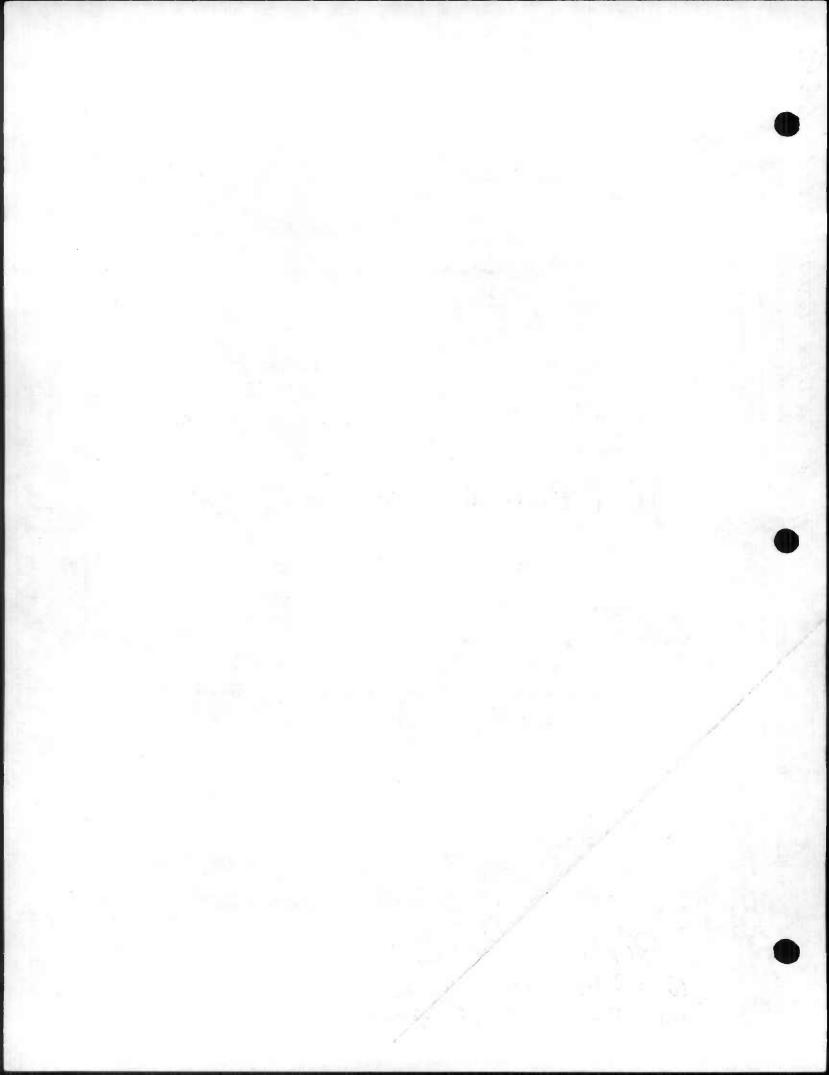
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) To the P 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatum and fittle of gertifier ey, us 30. Name and address of person who completed cause of death (High 23a) (Type, Print) Charles St. Balto and 2120% Riley

Registrar

31. Date filed (Month, Day, Year)

1 2 1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** 5:30PM Hoesch October George /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hapkins Bayriew Medical Center Baltimore N/A If Under 1 Year if Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) 6. Sax **Funeral** Months Days Hours Min. 1⊠M 2□ F 16 9295 83 Yrs. Feb 8, 1916 **Director** MD Usuai Rasidance of Dacedant the Maryland 10d. inside City Limits 10a State 10b County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Baltimore Baltimore 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7401 Eastern Ave 21224 USA death 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar In U,S. Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva 14. Race - Amarican Indian, 11. Marital Status Black, White, atc. permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Manual Hygiene. Importunit if them 27 is marked other than "natural", or then any injury or other traumatic avent. 1 XNavar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: White 2 3 Widowad 4 Divorced Year or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Welder Fence manufacturer 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Philip A. Hoesch Caroline Maurer 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) 7401 Eastern Ave Marie Hoesch /sister-in-law Baltimore, MD 21224 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20a. Method of Disposition Oct 12 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 1999 Sacred Heart of Jesus Baltimore, MD 4 ☐ Donation 5 ☐ Other (Spacify) 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 Kony plications that caused the fleath. Do not anter the mode of dying, such as cardiec or respiratory arrest, one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final angrene disaasa or condition rasulting in daath) Examiner Examiner peripheral vaccular disease ician and burial-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, atheroalerosis that the death certificate be Physician/Medicai Dua to (or as a consequence of): 88 980 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown artery disease þ 500 24b. Wara eutopsy findings evailable prior to complation of cause of deeth? Completed hypertensin 24a. Was an autopsy performed? diabetes 1 ☐ Yas 2 ☐ No 1 Yas 2 No 25. Was case referred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospital: Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 28a. Deta of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After 1 Qaturai or Attending 5 Panding invastigation 24 hours after death. 1 TYas 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicida Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Piace of Injury · At homa, farm, streat, factory, offica building, etc. (Specify) 4 | Homicida Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Cartifian edicai 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the F 100 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifical 98030 1 dr MD won 41

Johns Hopking Bayrice Medical Center, Baltimore 21224

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State

Registrar

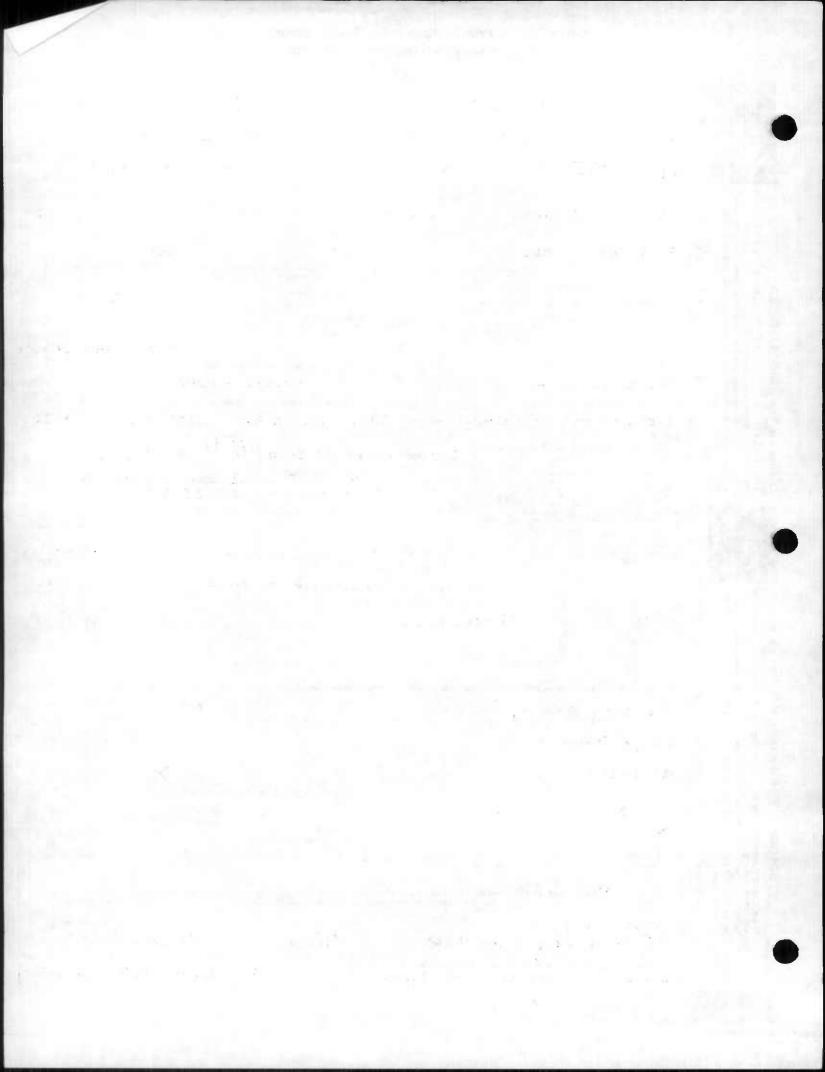
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31. Data filed (Month, Day, Year)

2 1999

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)
Stacia Regnolds, MO Johns Hopkins

32. Registrar's Signatura



Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Month Day October 7,1999 **Physician** Patricia Holland Vance 15:56 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (I not institution, give street and number) 4c. County of Death Examiner Himore Hospita 19 9. Birthplace (Stata or Foraign Country) 5. Social Security humber 8. Data of Birth 6. Sax 7. Age (In yrs. last birthday) **Funeral** -42-4958 Months Days Hours Min 1□M 2XF Yrs. Director and Usual Rasidenca of Decedent with the Maryland 10a. State 10b. County City, Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director outhmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 14. Race - American Indian, Black, White, etc. Herrs 23a Funeral permit. Peges 1 and 2 should be filed within 72 hours aftar deeth Department of Heelth end Mental Hygiena. Important: if Itam 27 is marked other than "natural", or Items 23. . Was Decedent Ever In U.S. Armed Forcas? 1 Yes 2 DNo If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Spacify Yas or No. If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Giva kind of work dona during most of working
ife. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **U**Catiantia 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) d Ediwar NKNOWN Jay 105 Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Ro ALSBURY MD.21801 ayne 20a. Method of Disposition 20b. Placa of Dispos camatary, cram Date Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 21. Signature of Funaral Service Licensee Buy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 28SU Approximata Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 7 Days SEPSIS OF UNKNOWN ORIGIN Examiner Due to (or as a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last and Due to (or as a consequenca of) physician Box 68760 thet the death certificate be Physician/Medical tha Dua to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. the signed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Splenomegaly Division of Vital Records, 2 law requires 24a. Was an autopsy parformed? 24b. Ware autopsy findings available prior to Completed peen Acute Renal Failure completion of cause of death? this certificate has The 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Chack only ona) 30 No Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes Inpatient 2 ER/Outpatient 3 DOA After this 27. Manger of Death 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) aftar 4 Homicide in 24 hou... Certifying Physician: To the best of my knowledga, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29b. Signatura and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 0 October 8, 1999 D52540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas J. Enelow St. Agnes HealthCare 900 Caton Avenue Baltimore, MD 21229

H

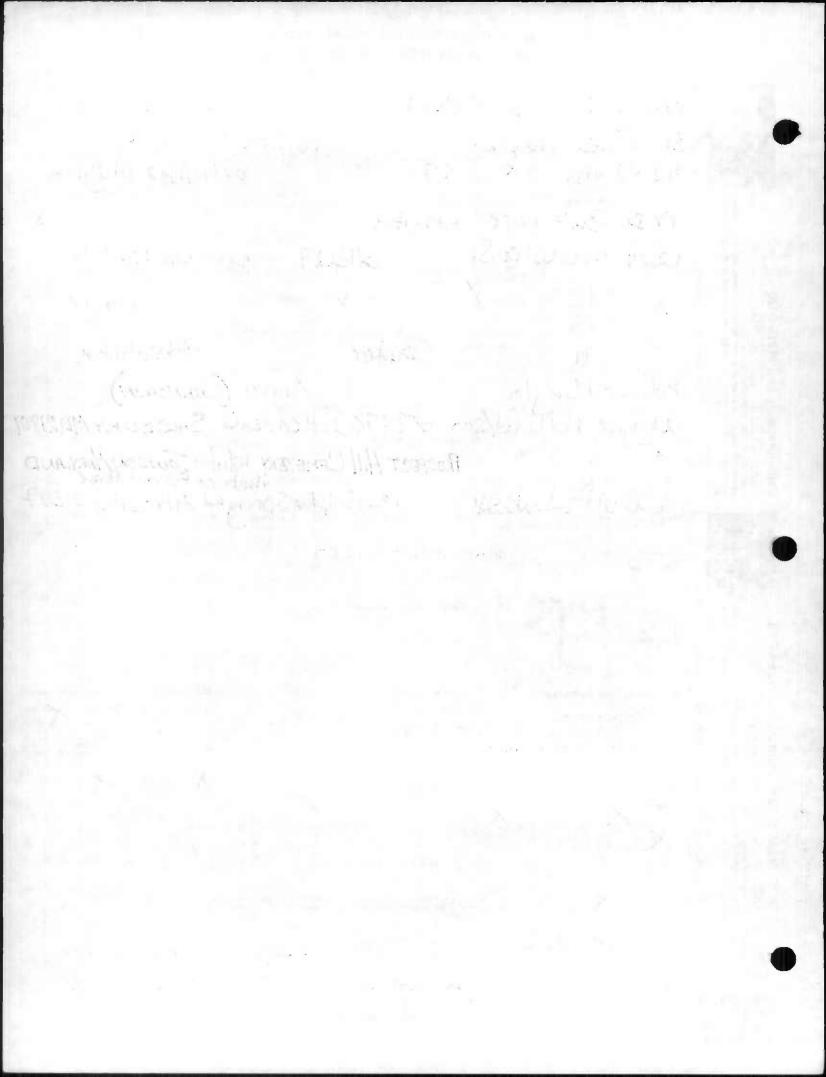
HOLLAND

NANCY

State Registrar 31. Date filed (Month, Day, Yaar)

OCT 12 1999

32. Registrar's Signatura B. Apark



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STUART HOBGEN 10:39 PM OCTOBER 09 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL, LOCH RAVEN BALTIMORE BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.

Months Days Hours Min. 5. Social Sacurity Number 6. Sex 8. Date of Birth (Month, Day, Year) (UN 28 1913 Birthplace (State or Foreign Country)
 M 1 M 2 F 212-03-1861 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits TEXES 2 No Md NA BALTIMORE 10e. Street and Number 10g. Citizan of What Country? USA 21234 3401 13. Was Dacedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Giva Year or Dates: 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 11 OFFICE WORKER E.L. GEEIF + BROS. NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) TOM G. HOBGEN KATHERINE EXALL 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MARY WEISH AU. BALTO Md 21234 2822 /NGLEWOOD 20b. Placa of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Qurial 2 Cremation 3 Removal from State 3/29 4 ☐ Donetion 5 ☐ Other (Specify) DRUIS Ridge BALTIMORE 22. Nama and Addrass of Facility ER FINERAL HEME, CHTD. 21. Signature of Funeral Sarvice Licansaa 7527 HARRORD Rd. Bullo Md. 21234 23a Fazi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION 4 DAYS 5 YEARS CORONARY Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of Due to (or es a consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiane. Important: if them 27 is merked other than "natural", or ther any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Records,

Division of Vital

tha Maryland

Examiner Physician/Medical þ Completed Be

attanding physician and for use as the bunel-transit tha Hospital or Attanding Physician: 74 hours after death. Funeral Director: After this cartificately filled in by tha funeral director, p. edicai Certification: To To the Hospital o within 24 hours eff To the Funeral Di complately filled in

State Registrar

DAJAY CHAWLA, MO

5 Pending Investigation

6 Could not ba

1 Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of cartifier

29a. Certifier

29c. Licensa number 12556

Decertifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

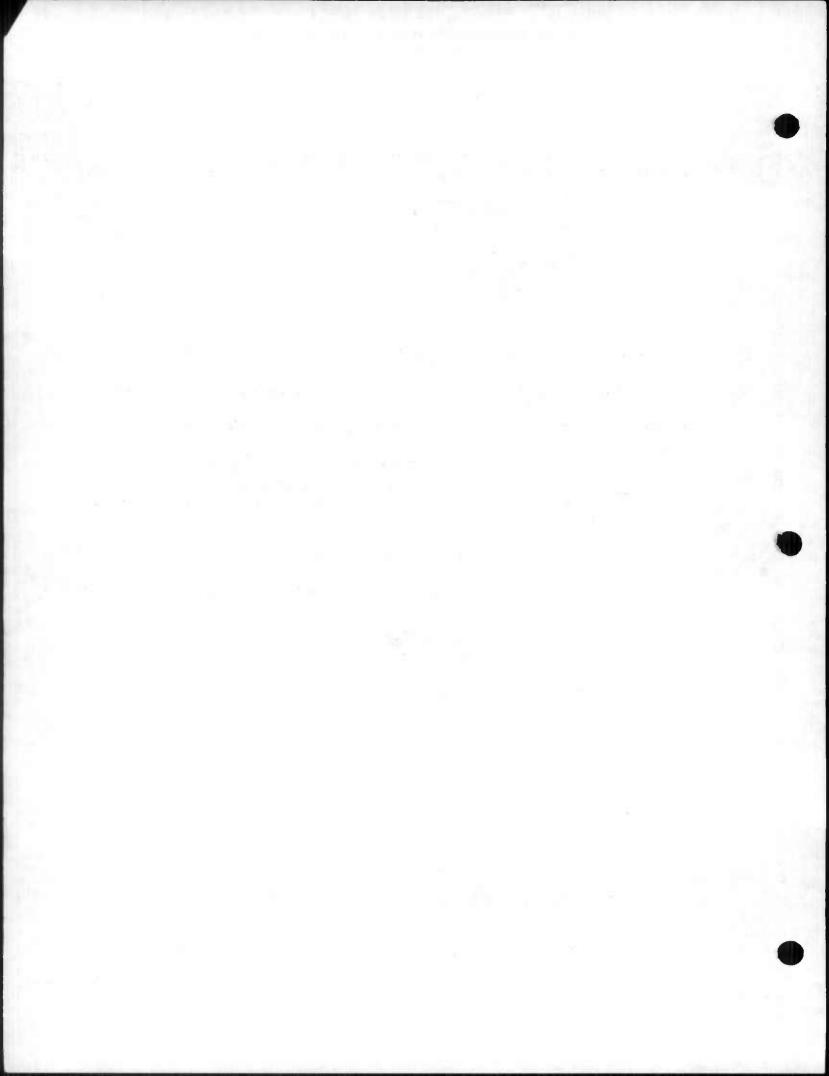
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJAY CHAWLA, MD, GODD JAMAKITAN HOSPITAL, LOCH KAVEN BUYD, BALTIMORE, MD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

32. Registrar's Signature

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Day Year Priscilla Α. Johnson 1:30pm 99 10 6 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore 2907 E. Monument St. If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) M.D. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Deys Hours 1□M 2√2 F Months MD 53 212-46-7652 08-19-46 Usuel Residence of Decedent 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 E. Monument Street 21205 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 7th Grade NA Housekeeping 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Theodore R. Scott Elizabeth Ballard 19e. Informent's Neme/Raletlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 Elizabeth Scott 2907 E. Monument Street Baltimore, MD. 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Cemetery 10-13-99 Baltimore, MD . 22. Name end Address of Fecility of Funaral Service Licensee Baltimore, Maryland 21202 1101 E. North Ave. March F.H. East Entire the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disaese or condition resulting in death) Cell Carcinoma Six Months Metastatic Sequantially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disaase or Injury thef Initiated avants resulting in deeth) Lest Dua to (or as e consequence of): Due to (or as a consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 ☐ Yee 2 ☐ No Kupe Hensson 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes casa raferred to medical axaminar? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury et Work? 1 Natural 5 Pending Invasfigation 1 ☐ Yas 2 ☐ No 2 ☐ Accident

the death certificate be executed physician end s the burial-trans Box 68760, 980 Records, P.O. Division of Vital Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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"natural", or items 23s

permit. Pages 1 and 2 ahould be find w Department of Health and Mental Hygien Important: if Iben 27 is marked other the any Injury or other traument

Physician

/Medical

Examiner

Examiner

Physician/Medicai

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Completed

edical

3 ☐ Suicida

29a. Certifian

4 Homicide

(Check only one)

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

or Attanding Physician: this n 24 hours after deeth.

Ne Funeral Director: After the further than 100 to 100 Hospital

completely within 2 State

29b. Signature and title of certifier a

12

6 Could not be determined

Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

00053702

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to the cause(s) and mannar stated.

1 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date end place, and due to tha cause(s) and mannar as stated.

29d. Dete signed (Month, Dey, Year)

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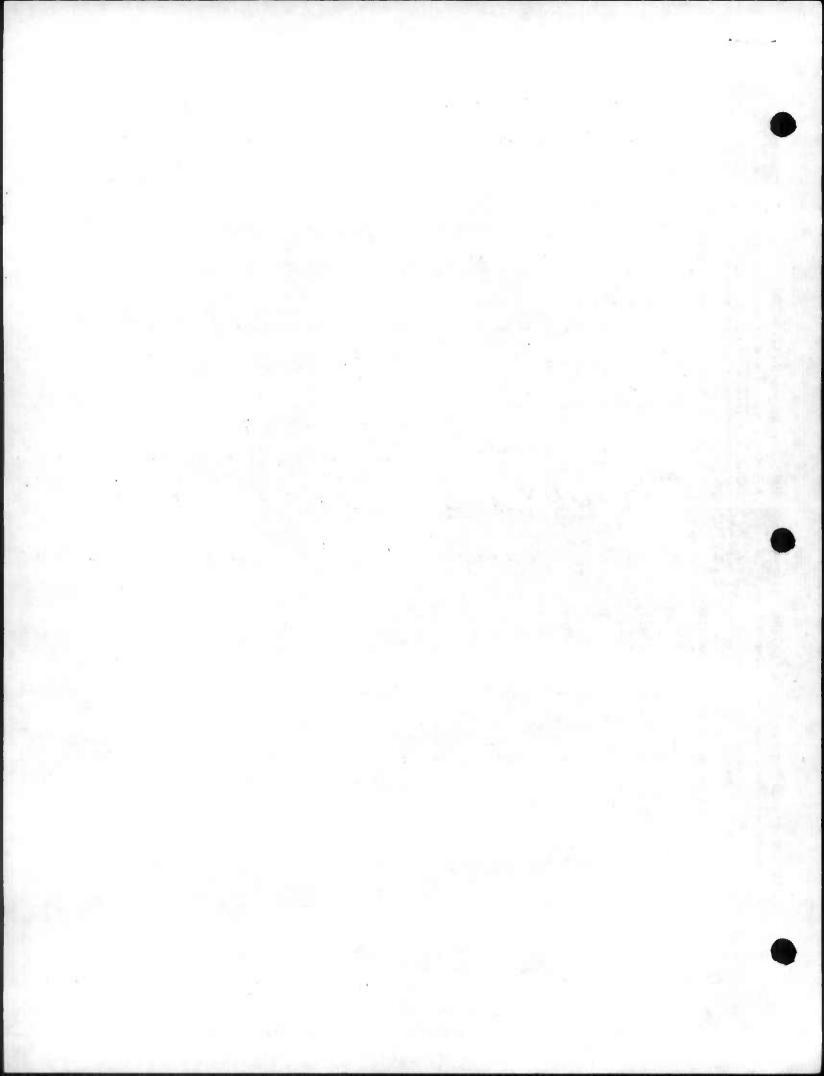
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Nema end eddrass of person who completed cause of death (Item 23a) (Type, Print)

MN

Johns Hopkins on wlogy lenter Baltimore 32. Registrer's Signeture

Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle-Last) GARLANS SE HWSON, SIR October ddie 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) ospital DAL HINGE Hemorial NION If Under 24 Hrs. 8. Date of Birth 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days 10 M 20 F 267 01 2332 Usual Residence of Decedent 85 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits BAHIMER LAYES 2 No Mory and Number 10f. Zip Code 10g. Citizen of What Country? USA LATRYEHE 21216 2404 Was Decedent Ever in U.S. Armed Forces? 1 Yes 22500 If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specity: Black Specify: 3€Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BE theken Steel Elementary/Secondary (0-12) College (1-4or 5+) WELDER 6 EGIAde 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) NIAH Jones JOSEPH JOHNSON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Baltimor, and 21237 Eddie JOHNSOM, JR. 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HLAUTUS, Marylows AKBUTUS nonevial land 22. Name and Address of Facility CHATHER - HARRIS FOR 21. Signature of Funeral Service/Utenaee eray Herry 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 0121 Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 2

24 hours efter death.

Registrar

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Director

with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Menylen Deportment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show mithy or other traumatic event, the Medical Engine, man the notified and interpret or notified.

Physician /Medical

Examiner

physician end the buriel-transit

USB

Physician/Medical Examiner

Completed

Medical

altimore, Maryland 21215-0020

31. Date filed (Month, Day, Year) OCT 1 2 1999

29b. Signature end title of certifier

29a. Certifier

(Check only one)

sollins, M.D. AT2438946
so of death (Hom 23a) (Type, Print) 201 East University Parkway
8220 Harvest BendLane #23, Laur 32. Registrar's Signeture

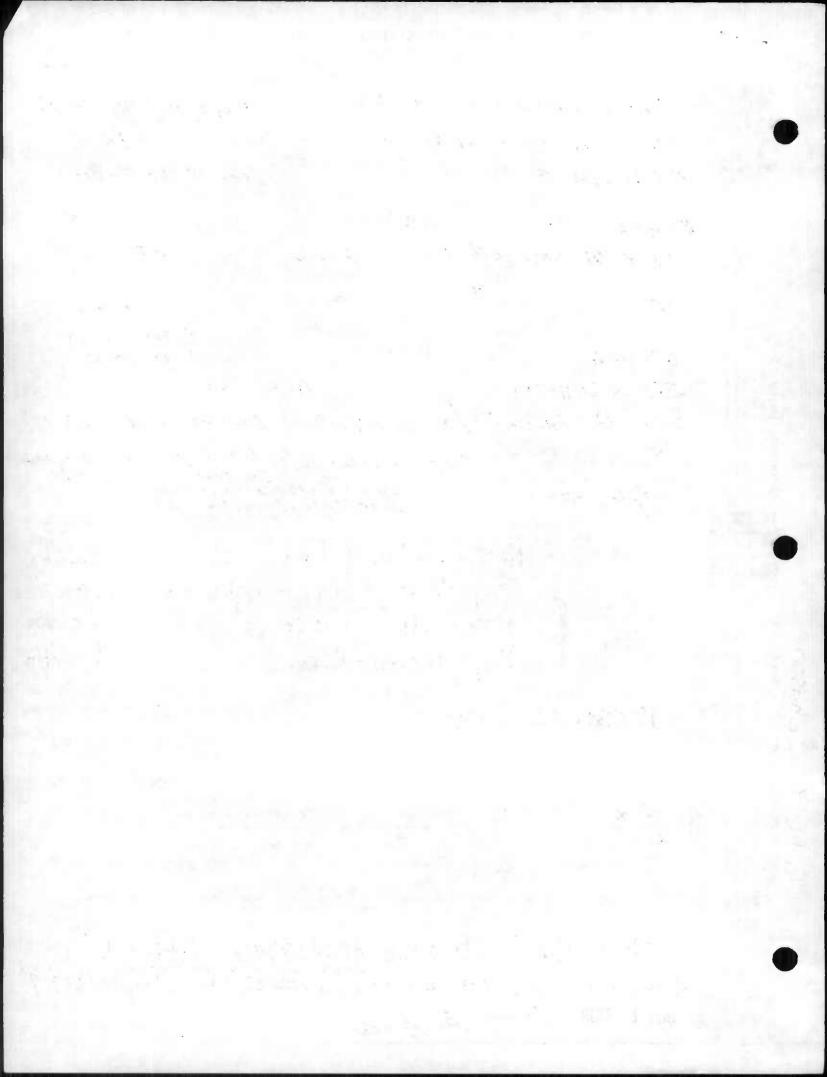
completed ceuse of death (Item 23a) (Type, Print) 201 East

1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

Baltimore Maryland 21218



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Physician 2:40 An 1999 OCH Bessie Muriel /Medical Keel 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Hospital Baltimore If Under 24 Hrs. 8 Da 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. 1□M 21 F Director 25 10 N.C. 10a. State 10b. County 10c. City. Town or Location r than "naturel", or items 23s or 28s-f show 10d. Inside City Limits 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Woodhaven Ave 21216 U.S. A. 14. Race - American Indien, 11. Marital Status 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiens. Important: if Nem 27 is marked other than "naturel, or Nan any injury or other traumatic ayent, the Medical Examinations." **Armed Forces** Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: þ 3X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade lyr Housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bryant Ward Alexzena Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Keel-Daughter 4008 Woodhaven Ave, Baltimore Md 21216 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Murial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Park 10/13/99 Laurel, Md 21. Signature of Funeral Service Licens March F/H West 23a Part Enter the disease or compleations that caused the death. Do not enter the mode of dying, such as cardiac of respiretory arrest.

Md shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final VOKR disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of): signed by the at id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings aveilable prior to completion of cause of death? E551 1 Yes 2 No 1 ☐ Yes 2 No Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No o this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 8 Hospital 24 hours a To the Hospital within 24 hours To the Funeral I completaly filled 29a. Certifier (Check only one) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) Merkane, MD u for los 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACNES HOSPITAL KANKONDE MUTOMBO 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State Registrar DHMH 16 Rev 6/95

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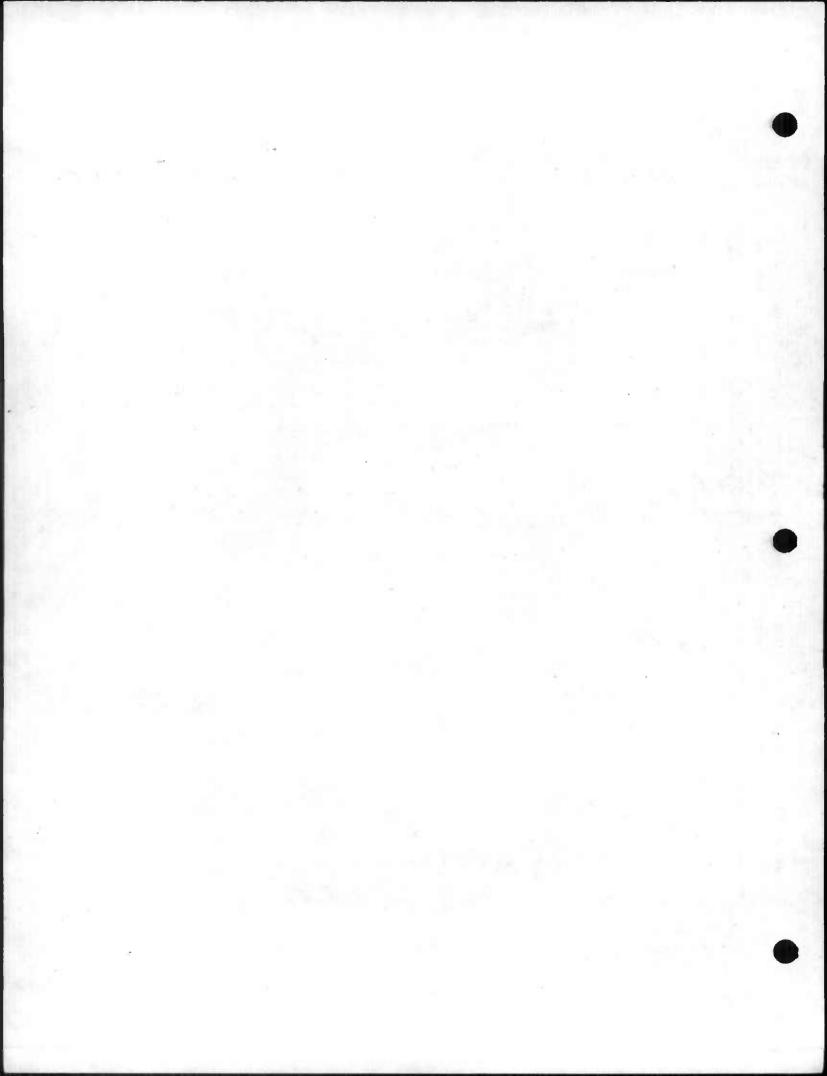
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			•	Certificate	of Death		Reg. No.			
Discontation	1. Decedent's Name (First, Middle, La	st)		1/		2. Dete of De Month	ath Day	3. Time	of Death	
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Examiner	4e Facility Neme (If not institution, giv	e street end number)			4b. City, Town, o	r Location of Deetl	4c. County	of Deeth		
	THE JOHNS HOPK	INS HOSPIT	AT.		BAI.TIMO	RE CITY	N/	'A		
Funeral	5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last birt	hday) If Under 1 Y		s. 8. Dete of Bir		9. Birthplece (Stat Country)	e or Foreign	
Director	192-14-1845 X	M 20 F	77	Yrs. Months D	Bys Hours Wil	1/29/2		PENNSYLV		
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er death with the Maryla herre 23a or 23a-f shor net must be notified at uneral Director	MD BALTIM	ORE	н	ILLENDALE			1 ☐ Yes 2√ No			
or 28a-1 s be notified Director	10e. Street and Number			10f. Zip Co			10g. Citizen of	Whet Country?		
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Esami	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Detes:		If Yes, specify	of Hispenic Origin? (Cuban, Mexican, Pue No Specify:	erto Rican, etc.)	Specif	ck, Whita, etc. WHITE		
ygiene. Ner then "natur It, the Medical. Completed	15. Decedent's Ed	ducation	16a.	Decedent's Usuel O	ccupation one during most of w	a delin a	16b. Kind of B	usinass/Industry		
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svent, Be C	17. Fether's Neme (First, Middle, Last)					ema (First, Middla,				
9 0	PETER PAUL KANIS				JOSEPH	INE KOPIT	SKT			
-	19e. Informent's Neme/Reletionship (19b.	Mailing Addrass (St	reet end Number or I			, Stata, Zip Code)		
Table 1										
f)	MARY KANIS 20e. Method of Disposition	WIFE	20b. Pleca of	O18 DALES Disposition (Neme of	of	Date	ALE, MD	21234 City or Town, Stete		
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	23e. Perit. Enter the diseese, or com shock, or heert tailure. List only	plications that caused	the deeth. Do n	ot enter the mode of	dying, such es cardi	ac or raspiratory a	rast, ME	21286 Approxim	nate	
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by Physician/M	_	J								
SIC	Pert II. Other significant conditions of	ontributing to deeth bu	it not resulting in	the underlying caus	e given in Pert I.	23b. Did	tobacco une co	entributa to the caus	e of death?	
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by F	NONE					-				
should be letted to							an autopsy	24b. Were eutops	y tindings	
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To Be (25. Wes case rafarred to madical axaminer?	Hospitel:				eath (Check only	one)			
2	1 ☐ Yes 2 No	1 og Inpatie				Home 5 ☐ Resi	denca 6 □Ott	ner (Specify)		
	27. Mennar of Death 1 □ Natural 5 □ Panding	28a. Date of Injui (Month, Day		ime of 28c.	Injury et Work?	28d. Describe	how injury occur	red		
ati	2 Accident investigation			М	1 ☐ Yes 2 ☐ No					
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edical	29e. Certifiar Certifying Ph (Check only one)	ysician: To the best of liner: On the basis of end menner ste	examinetion end	daath occurred at the	ne time, date and plan my opinion, deeth oc	ce, and dua to tha curred et the tima,	causa(s) and m deta and placa,	annar as stated. end due to the caus	e(s)	
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	30. Name and addrass of person who			**					,	
	JEREM ZA WILLI		NORTH WO	4E STREET	BACTIM	OLE , MARY	AND	21187-910	6	
State	31. Dete tiled (Month, Day, Year)		er's Signeture	, ,						
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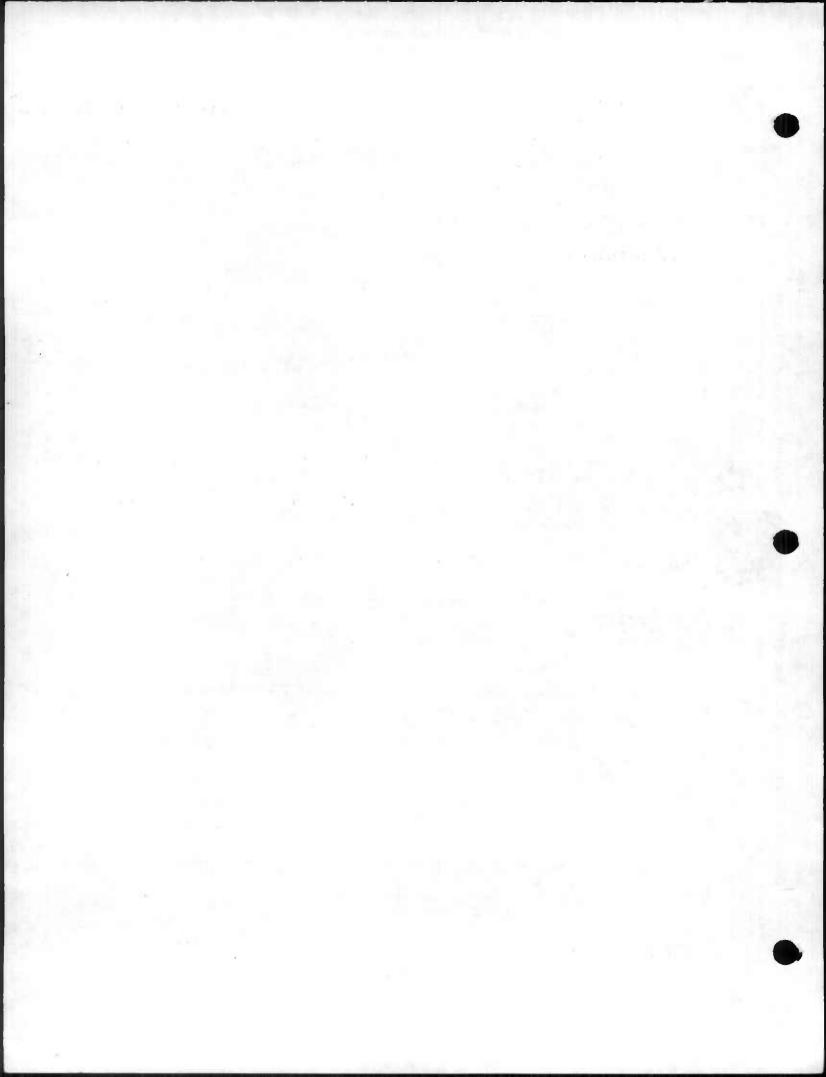
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State of Maryland / Department of Health and Mental Hygiene

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	/Medical Examiner	4a Facility Name (If not institution	n, give street and numb	er)			4b. City, Town,	or Location of Deat			2.13 11.111	
		Mariner Heal	th of North	Arunde	1		Glen Bu	ırnie	Anne	Arunde	21	
	Funeral	5. Social Security Number		Aga (In yrs. last	birthday	/) If Under 1 Year Months Dey		Hrs. 8. Date of Bir /Month, Da	th Veer)	9. Birthplac	ce (Stete or Foreign	
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	P .	Usual Residence of Decedent 10a, State 10b, County		10- Ch. T						Land		
	show and			10c. City, T						10d.	Inside City Limits	
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	vith the Ma to 28e-f be notified Director	10e. Street and Number	m . !			10f. Zip Code			10g. Citizen of 1		7	
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	fer death v free 234 oner men	11. Merital Status	12. Was Decede Armed Force	s?	13	 Was Decedent of If Yes, specify Cu 	Hispanic Origin's ban, Mexican, P	(Specify Yes or No uarto Rican, atc.)	- 14. Rac Ble	e - American ck, White, etc		
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	/Medical Examiner	Immediate Cause (Finet disease or condition resulting in death)	8.	Houte	1 /	Lyocar	did	Inford	Son	1	Lours	
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90	berie burie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es a consequence of): if any, leading to immediate cause. Enter Underlying C. Due to (or es a consequence of):										
68760,	physicians the bu	resulting in death) Last		Due to (or es	a conse	equence of):				į		
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o i	The lew requires that the deeth certifies the been signed by the ettending page 2 should be deteched for use a Completed by Physician/M.	Part II. Other significant condition			_	underlying cause (given in Pert I.	23b. Dld	tobacco use co	ntribute to th	he cause of death?	
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								10	Yes 2 No	1 D Y	res 2□ No	
Vitai	certificate rector, pag	25. Was case referred to medica examiner?	1				26. Piece of	Deeth (Check only o	one)	1		
5	this or	1 Yes 21 No	Hospitel: 1 ☐ Inpe	atient 2 ER	Outpation (ent 3 DOA	ther: 4 Nursin	g Home 5 ☐ Resi	dence 6 □Oth	er (Specify)		
U .	Attending Physicien: r deeth. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death 1 Netural 5 □ Pendir	28e. Date of I	njury Day Year) 28	b. Time Injury	of 28c, Inj	ury et ork?	28d. Describe	how injury occur	red		
0	leeth. lor: After the funer cation	2 Accident investi	getion			M 1	Tyes 2 □ No					
	a ster deeth. I Director: After to In by the funeri	3 Suicide 6 Could 4 Homicide determ	nined 288. Piece of	Injury - At home etc. (Specify)	, larm, s	treet, lactory, offic	9	28f. Location (City or To	Street end Numb	per or Rural R	loute Number,	
	us or Attending in a ster destr. I Director: After to led in by the funeral Certification:											
	24 hours effort and the stelly filled in	29a. Certifier 1 NCertifyir	ng Physician: To the be Examiner: On the basis	st of my knowled	ige, dee	th occurred et the	time, date end pl	ece, end due to the	cause(s) and m	anner as state	ed.	
	within 24 hours after to the Funeral Direct Completely filled in Medical Certi	ane)	end menner	steted.	Jing Of 1			source or the filler				
	within To the comple	29b. Signature and title of certifie	1	10			nse number		29d. Dete signe			
	1	MAGU	Loney 1	NW.		D-	40521		Octobe	x 5,1	999	
	Da 10)	30. Name end address of person	who completed cause o	f death (Item 23	a) (Type	, Print) 784	5 Cal	kurod	Road	Suit	205	
	111	DR. OCH	ANEJ		-6	Hen B	wrie	no	21061			
	State	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature		8	-					
	Registrar	00	T 1 2 1999	Sever	4	D. M.	ooks					



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death October Year **Physician** 1999 3511 Rose Karp /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Milford Manor Nursing Home Pikesville Baltimore If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stata or Foraign Country) New Jersey **Funeral** Days 1□ M 2□ F Months Hours Director 092 09 5693 09 03 1912 Usual Rasidance of Decedant death with the Maryland 10e. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location **ehow** r than "natural", or items 23a or 28a-1 shorted at 1 ☐ Yes 2 ☐ No Director Baltimore Pikesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 4204 Old Milford Mill Road. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be liled within 72 hours after c Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than "intural", or Nem any Injury or other traumatic event, the second points. Black, Whita, atc. 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No If Yas, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 80 Ida Levenson Louis Silverman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Retetionship (Type, Print) 3925 Setonhurst Rd. Baltimore, MD 21208 Shirley Gordon/ Daughter 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, Stete Lakeside Mem. Park 1 □ Buriel 2 □ Cremetion 3 □ Removal from Stete Miami, FL 10/10 4 □Donation 5 □ Other (Specify) 22. Name and Address of Fecility
Sterling-Ashton-Schwab Funeral Home 21. Signeture of Funeret Service Licensee K Marsha 736 Edmondson Ave. Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final Men diseese or condition resulting in death) Examiner Examiner that the death certificete be axecuted physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or as e consequence of) signed by the attending the detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 1 Yes 2 No 1 Yes 2 No certificate or Attending Physician: director. 89 25. Was case rafarred to medical examiner? 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 Yes 2 Nd 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient this 27. Mannar of Beeth 28e. Dete of tnjury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? As Hospital or As.
1-1-24 hours after death.
1-1-24 hours after death.
1-1-25 hours after the livestor. 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) In 24 hour.
The Funeral Direction by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier (Check only one) Medical To the Hosp within 24 ho To the Fune completely f 29b. Signeture and le of certifier 29d. Date signed (Month, Day, Year) 30. Name and eddrass of pr who completed cause of death (Item 23a) (Type, Print) Randallstraw Road 5310 W

DHMH 16 Rav 6/95

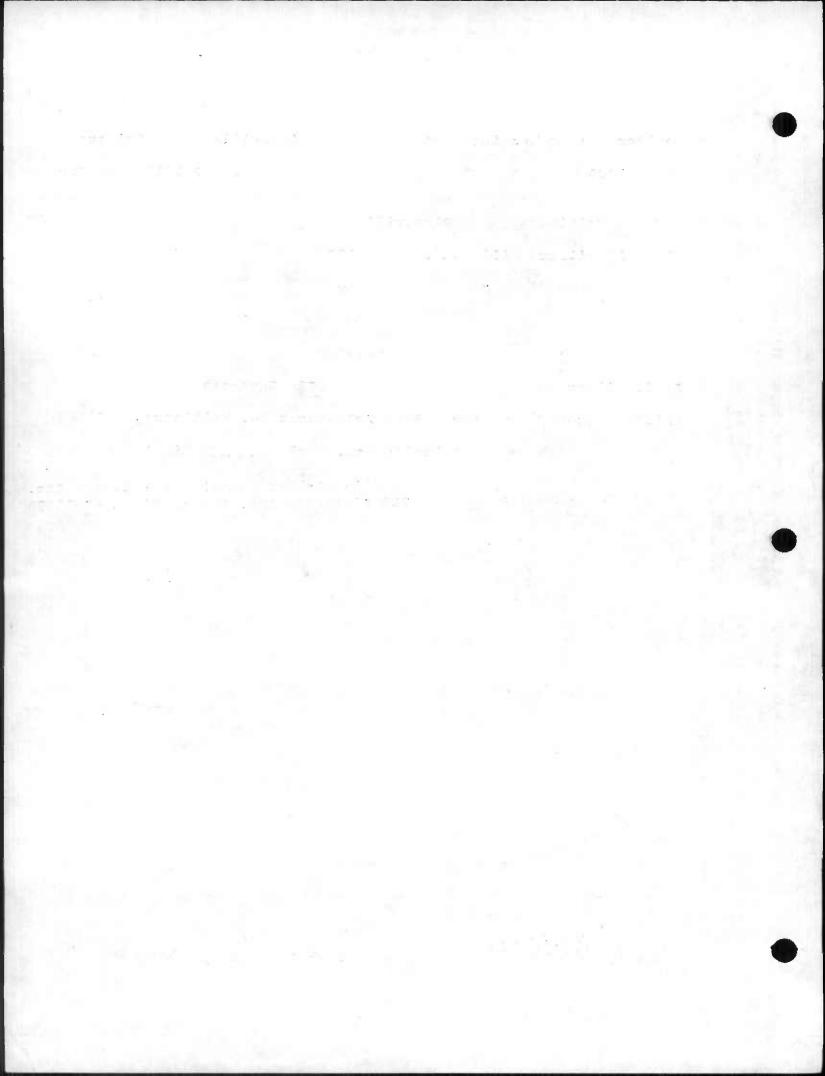
State

Registrar

31. Date filed (Month, Day Year)

OCT 12

32. Registyar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#20a perFH G776 10/12/99 EW 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth October . 1999 MILDRED ALDRIDGE KENT 6:45 PM 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N H Under 24 Hrs. 8. Date of Birth (Morph, Day, Year) NOV. 21, 1920 92 AR GROVE APT NIA 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthpiace (State or Foreign Days 10 M 20XF Months 212-18-567 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No MARYLAND 10e. Street and Number 10f. Zip Code Og. Citizen of What Country? 40 JROVE USA 12. Wes Decedent Ever/in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 □ Never Married 2 □ Merried 1 Yes 2 No Specify Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RIVATE TOMES 6 + HGRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1A-MES MURRAV 1AR1/LOU 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 21218 VUIDA THOMAS BALTIMORE DAUGHTER 20a. Method of Disposition 20a. Method of Disposition 3 □ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State GARRISON FOREST 4 □ Donation 5 □ Other (Specify) OWINGS MILLS, MD. 21. Signature of Funeral Service Compac 22. Name end Address of Facility JR. FUNERAL HOME OSEPH H. BROWN 40,2121 MAY FULTONAVE 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory agest stjock, or heart feiture. List only one cause on each line. Approximate tntervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) DEON 1 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Du to (or es e consequence of) on Criptio Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

PV

Completed

Be

Funeral

Director

Nem 27 is marked other than "natural", or Name 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within. Department of Health and Mentel Hygiene important: if Item 27 is marked other than "neny Injury or other treumatic aware

the Maryland

72 hours after

Saltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

certificate be

Examiner

attending physician and for use as the burial-transit funeral

has

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Physician/Medical by Completed Be

Division of Vital s after death. or Attending in by t To the Hospital Within 24 hours To the Funeral State Registrar

0 Certification:

edical

3 ☐ Suicide 4 ☐ Homicide 29a. Certifier (Check only

27. Magner of Death

1 2 Natural
2 Accident

1 Yes 28 No

6 Could not be determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

place 21202

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Residence 6 Other (Specify)

29b. Signeture end title of certifier

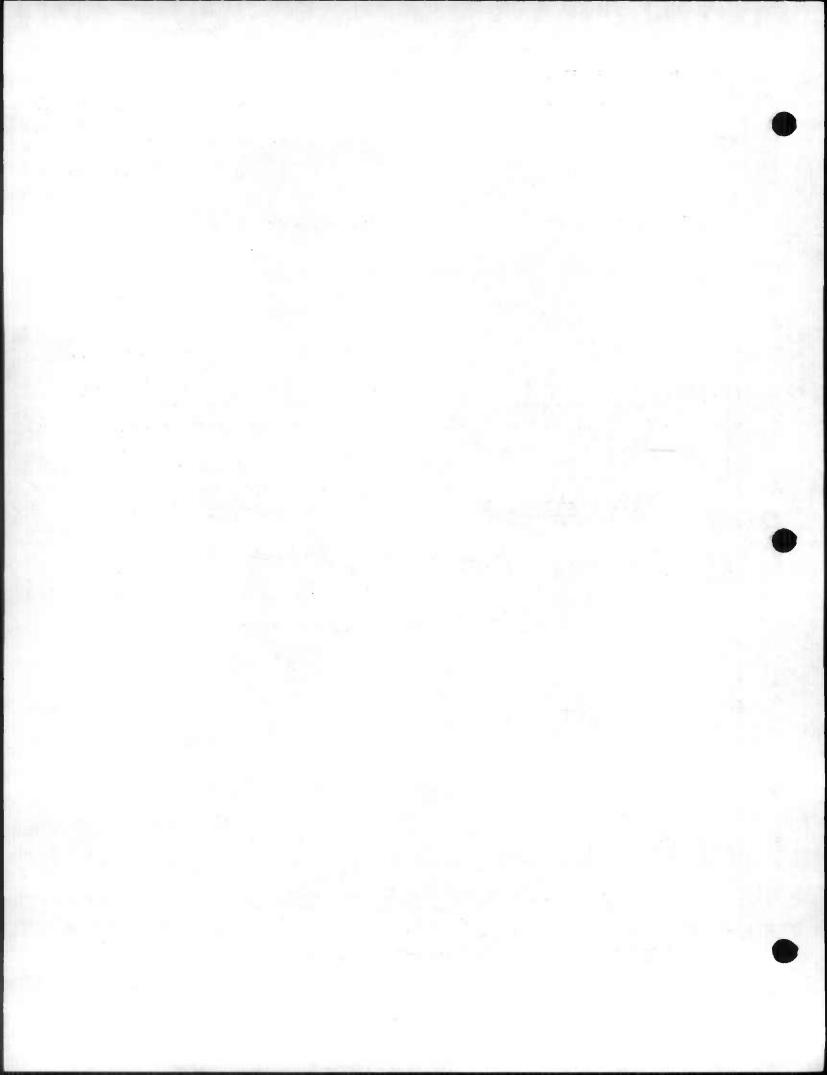
29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of p who completed cause of death (Item 23a) (Type, Print)

M AVSM 31. Date filed (Month, Day, Year)

32. Registrar's Signeture



9

9-607; MICHAI KNOX	ΞL		Type or Print I State of Mary 1,27,28						31	7 8	
	ysician Andinal	MICHAEL JE	FROME	KX	JOX		Month OCTOBER	B, 199	Yeer	3:49P.M.	
	Medical aminer	4a Facility Name (If not institution, give	street end number)			4b. City, Town, o	r Location of Death	4c. County			
N.		GOOD SAMARITAN HOS		and the same to be de-	oday) If Under 1 Ye	BALTIM ar If Under 24 H					
Fun Dire		5. Social Security Number 6. Se 11 Usual Residence of Decedent	20 F 7	yrs. last birtl	rs. Months Day			53	9. Birthplac Country	(State or Foreign	
deeth with the Maryland ms 23a or 28a-f ahow	led at	10a. State 10b. County	10	c. City, Town	or Location	RE			10d	I. Inside City Limits 1 Yes 2 No	
ith the Mi	lrec	10e. Street and Number			10f. Zip Cod	9	100	g. Citizen of W	hat Country	17	
23a c	d le	9636 BRIE	Ct		21	133	Name of	USA			
	Fune		12. Wes Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give	in U,S.	13. Wes Decedent of If Yes, specify C	uban, Mexican, Pue	(Specify Yes or No- orto Rican, etc.)	Indien,			
5-0020 72 hours after netural", or he	d by		Yeer or Detes:						40/6		
within 72 i	r, the Medical	15. Decedent's Edi (Specify only highest grad	cation de completed) College (1-4or 5+)	16a. l	Decedent's Usual Oc 'Give kind of work do life. DO NOT use ret	ne during most of w ired)	orking 16	king 16b. Kind of Business/Industry			
offe, mar yland a standard a standard a standard should be filled of Health end Mental Hygi tem 27 is marked other other traumatic event,	CO II	11			i	INK		NIC	1/2		
	o Be		cu o s			18. Mother's N					
		GEORGE #	voe. Print)	19b.	Meiling Address (Str	I RE	Rural Route Number,	City or Town	State Zin C	ode)	
	r frau	OF/ESTE K	NOX	9,	636	BPIF	of	ony or rown,	otaro, Elp o	500)	
	y or oth	20a. Method of Disposition 1	Removel from State	Ob. Place of cometery	Disposition (Name of cremetory or other)	olage) OHOL	Date 20	RANDA	City or Town	State MD.	
pemit. Page Department of Important: if	any injury	21. Signature of Figneral Service Licens Muchae	Ziglier	7.70	22. Name and Ad	dress of Facility	Heights		uto. p	10.21207	
Physic /Med	_	23a. Pert1. Enter the disease, or comp shock, or heart lailure. List only o	ne cause on each line.		ot enter the mode of o			t,	lr lr	opproximete intervel Between Onset end Death	
Exami		disease or condition resulting in death)	a			E INIOA.	LCATION				
20			Oue	to (or as a co	onsequence of):						
U, axecuted an and	riai-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		1							
v requires that the death conflicte be asse	etached for use as the bu Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):									
deati	sicle	Part It. Other significant conditions co	ntributing to death but no	t resulting In	the underlying cause	given in Part I.	23b. Did tob	acco usa con	tribute to ti	he cause of death?	
requires that the	be detach by Phy						1 🗆 Yes	2 □ No	3 Probe	bly 4 Unknown	
law requires t	Completed t		<u> </u>			181	24a. Was en performe	eutopsy ed?	evail	a autopsy lindings able prior to pletion of cause eath?	
The law	Se Peg						/ Yes	2 □ No	100	Yes 2□ No	
Physician: rthis certific	B. Be	25. Wes case referred to medical examiner?	Hospital:		1,		eath (Check only one,				
this of	in To	1XX Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Dete of Injury	2 ER/Out	Matient 3LJ DOA		Home 5 ☐ Residen 28d. Describe how				
Affa S	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea 10-8-99	er) Ini	ury V	Vork? □ Yes 2\(\)\(\)\(\)\(\)\(\)	UNKNOW				
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes	led in by the funer Certification:	3 ☐ Suicide 6 ☼ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, lerr pecify) HOME	n, street, lactory, office	29	28t. Location (Street and Number of Bural Figure Number of City or Town, State) BALTIMORE, MD				
Hospita 24 hours Funeral	edical C	29a. Certifier 1 Certifying Phy	sician: To the best of my ner: On the basis of exa and menner steted.	knowledge,	death occurred et the or investigation, in m	time, date and placy opinion, death oc	ce, end due to the ceu	se(s) end me	ner es stat	ed. ne cause(s)	
o the o	Me M	29b. Signature and title of certifier	and mornior stated.		29c. Lice	ense number	290	I. Dete signed	(Month, De	y, Year)	
H 3 H	o	M Araluk	co (M)		0	.C.M.E.	00	TOBER	9.1990	9	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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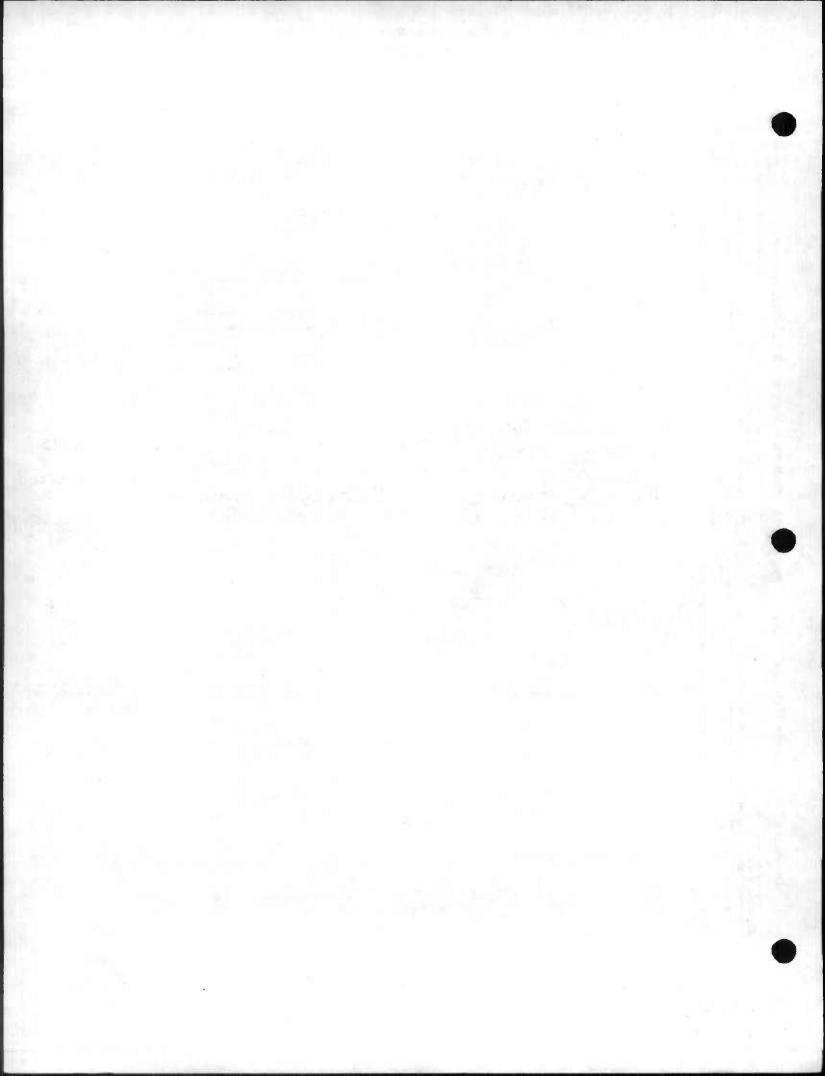
31. Dete filed (Month, Day, Year)

OCT 1 2 1999

32. Registrer's Signeture's COT 1 2 1999

111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death **Physician** 1999 1:45 PM october lam /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Battimore Manor Nursing Home Baltimore geway If Under 24 Hrs. 6. Sex 1 M 2 □ F If Under 1 Year 7. Age (In yrs.-last birthday) 90 Yrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 214-05-2517 Mary Director Usual Rasidance of Dacedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show altimore R 1 Yas 2 No Dattimes 10a Street and Number 10f. Zip Code 10g. Citizen of What Country 23a or Solmon Son Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No or Merna Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White þ Widowed 4 □ Divorced "natural" Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "any Injury or other treumatic event, the Mapping." College (1-4or 5+) Stee mak 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be William Elsworth 19a. Informant's Name/Ralationship (Type, Print) 199 Mailing Address (Street and Number of Roral Bouta Number, City or Town, State, Zip Code) law 341 Homberg Ave Essex MD Tomblin brother-lin 20b. Place of Disposition (Name of cametery crametery crametery or others 20a. Mathod of Disposition

Burial 2 Cramation 3 Removal from Stata 20c. Location - City or Town, Stata leadow rida 10/14 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signaluly of Funeral S 22. Name and Addrass of Facility Ambro 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or dispiratory arrest, shock, or haart failure. List only one cause on each line. Le butus 21227 MO **Physician** /Medical Myocardial Immediate Cause (Final diseasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Shoke physician and the burial-transit Sequentially list conditions, if any, taading to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic 055hu 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 1 NO 1 ☐ Yas 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Natural 2 Accidant 5 Panding invastigation William 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) mh 19558 1999 October 98 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Suite 205. 716 Maidenchoice Lang Glen E Johnson MD. Baltimore, Maryland 21228 maryland

Registrar

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State

31. Data filed (Month, Day, Year) OCT 12 1999

32. Registrar's Signatu

and the way where the same of the same

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Robert Lee Lafferty October 7, 1999 10:30AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13233 Old Hanover Rd. Reisterstown Baltimore | H Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | Sept. 23,1935 5. Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country)
 MD 7. Aga (In yrs. last birthday) **Funeral** Months Yrs. 212-32-0712 64 Director Usual Residence of Decedent 10c. City, Town or Location v 28a-f show 10s. State 10b. County 10d. Inside City Limits the Marylar 1 Yas 2 XNo Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 늅 ir then "natural", or items 23s or the Medical Examiner must be r 13233 Old Hanover Rd. 21136 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Giva Year or Dates: Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Insportant: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Samuel Lafferty Margaret Hare 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13233 Old Hanover Rd. Reisterstown, MD 21136 Date 20c. Location - City or Town, State Shirley Lohmeyer 20b. Place of Disposition (Nama of cemetery, crematory or other placa) 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from State ö Lake View Memorial Park 10/9/99 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee 11824 Reisterstown Rd. 23a. Fart1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, clock, or heart failure. List only one cause on each line. Reisterstown, MD Approximate Intarval Batween **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical a adenocarcinomA OF THE LUNG (UND IFFERENCIATED) Examiner Due to (or es e consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events rasulting in death) Last Due to (or as a consequenca of) P.O. Box 68760. Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown PNEUMONIA Division of Vital Records, þ been sig 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy parformed? page 2 s 1 Yes 2□ No 1 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2N No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: 1 Natural 2 Accident 5 Pending in 24 hours after the Funeral Director: After Funeral Director: After the funeral filled in by the funeral funeral filled in by the funeral fu 1 TYas 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) within 2 29d. Data signed (Month, Day, Year) 29b. Signature and till of certifie OCTOBER, 8Th 30. Neme and address of person who complete I cause of death (Item 23a) (Type, Print)

3100 TIMANUS LANE BALTIMORE, MD 21244

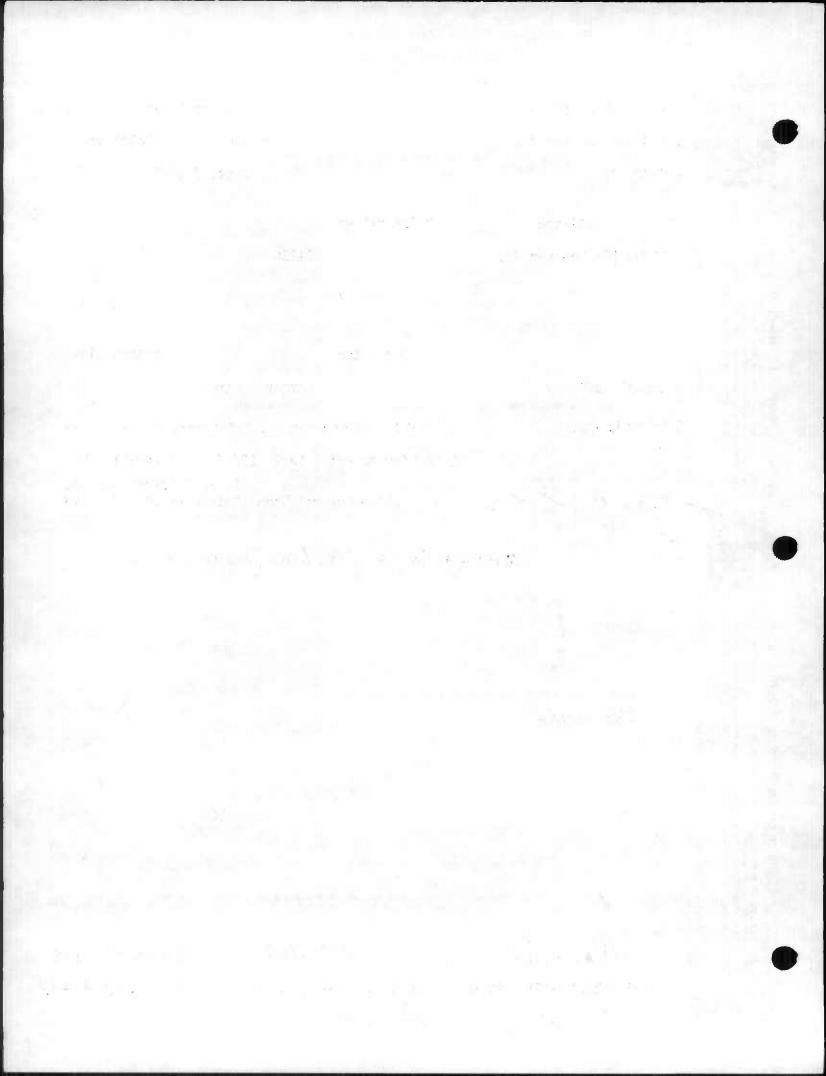
State Registrar

RAYNOLD

31. Date filed (Month, Day, Year) OCT 12

DEPESTRE

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** 8,1999 LIVINGSTON 6:45F ROKIA October /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-09-90 HOPKINS HOSPITA ZOHNS NA 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number Birthplace (Stata or Foraign Country) **Funeral** Deys 1 M 20XF Director 215-31-0771 MD Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD NA Baltimore 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4758 Edison Avenue 21206 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Evantment page. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0020 p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) College (1-4or 5+) Student Student 4th Grade 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Rhonda Chase Livingston Derek L. 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Rhonda Chase 4758 Elison Avenue Baltimore, MD. 21206 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Buriel 2 ☐ Crametion 3 ☐ Removal from Steta Arbutus Mem. Pk. Cem. 10-13-99 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama end Addrass of Facility Baltimore, Maryland 21202 union of Funaral Sarvice Licenses WM.C.March FH 1101 E.North Avenue 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on each line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immedieta Ceuse (Final RRAW INJURY disaasa or condition rasulting In death) RAUMATIC Examiner Dua to (or as a consequence of) Examiner physician and s the burial-transit be axecuted Sequentially list conditions, if any, laeding to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated evants resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical The law requires that the death certificate Dua to (or as e consequence of) signed by the aid be detached for P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ Records. 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 a 1 Yes 2 No 1 ☐ Yes 2 X No certificate Division of Vital al or Attending Physician: The safter death.

I Director: After this certificate of in by the funeral director, ps Be 25. Was casa rafarred to medicat 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yas 2□ No 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending October 6,1999 4:00 PM 1 ☐ Yas 2 No invastigation AUTOMOBILE ACCIDENT 2 Accidant 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel Di completely filled in Anne Arundel Carry STRE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29a. Certifian (Check only one) 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar

DHMH 16 Rev 6/95

MYNNE 31. Dete filed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MORRISON,

32. Registrar's Signature

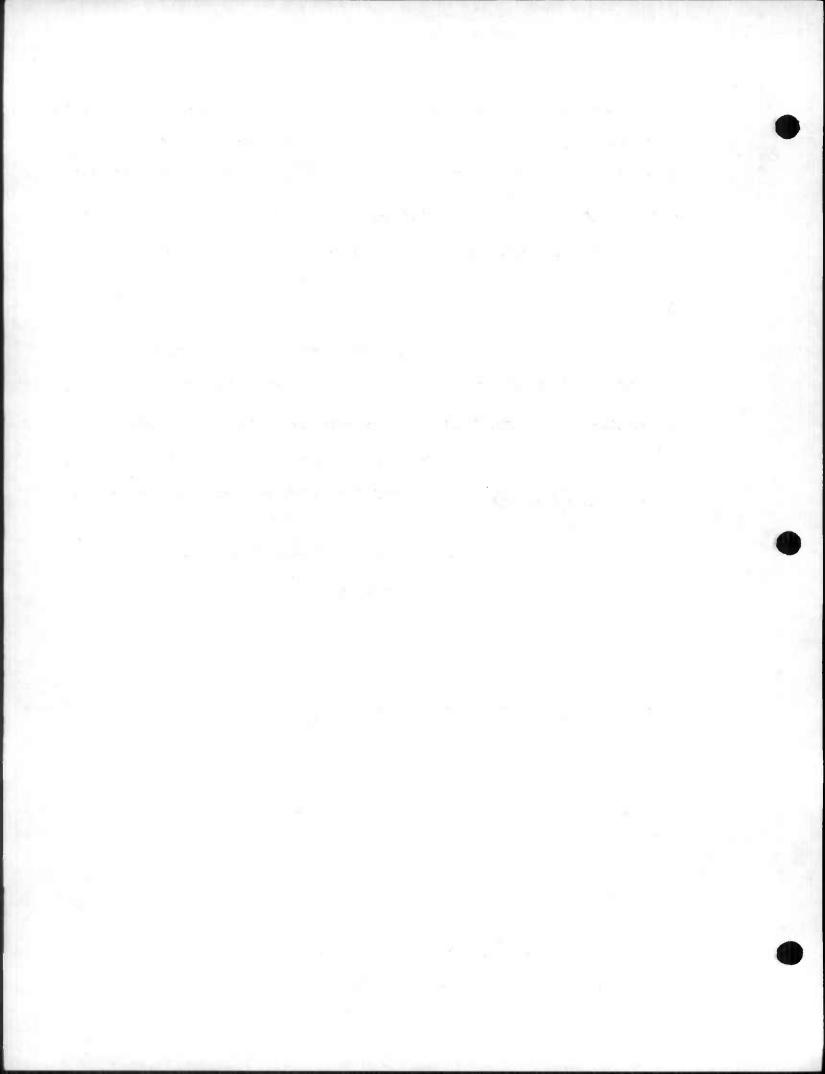
D0053215 October 8,1999

JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21205

State of Maryland / Department of Health and Mental Hygiene

99 31722

					C	Certifica	te of	Death		Re	g. No.			
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s 1 end 2 of Health a ftem 27 is other trai	1	Mr. William A. I	enz, Jr.	(Son)	19	64 Po	lari	s Road	Finl	ksburg	, Mary	land 2	1048	3
pemil. Pages 1 e Department of Hei Important: If item any injury or othe		20a. Mathod of Disposition			Place of D	isposition (No	eme of other ple	ca)	0	ete 2	Oc. Location -	City or Town	n, Stata	
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mit.		21. Signature of Funaral Sarvica Lice	nsaa	1				ass of Facility				050 Yo	_	
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puet % =		10a. State	10b. County		10c. City	y, Town or Loc	ation					10	0d. inside City Limits
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ath w	rai	4529 Ak	ron Street					2074				SA	
or fr	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2 Married	12. Was Decedent Armed Forces' 1 Types 2 If If Yes, Give Year or Detes:)	lf.	Vas Decede Yes, specif	ly Cuban,	penic Origin? (S Mexican, Puert Specify:	pecify Yes or Ni o Rican, etc.)	No- 14. Rece - American Indien, Black, White, etc. Specify: White		
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- Page	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Plece of In building, e	jury - At ho tc. (Specif	ome, farm, stre	et, factory,	office		28f. Location City or To	(Street end Num own, State)	ber or Rure	el Route Number,
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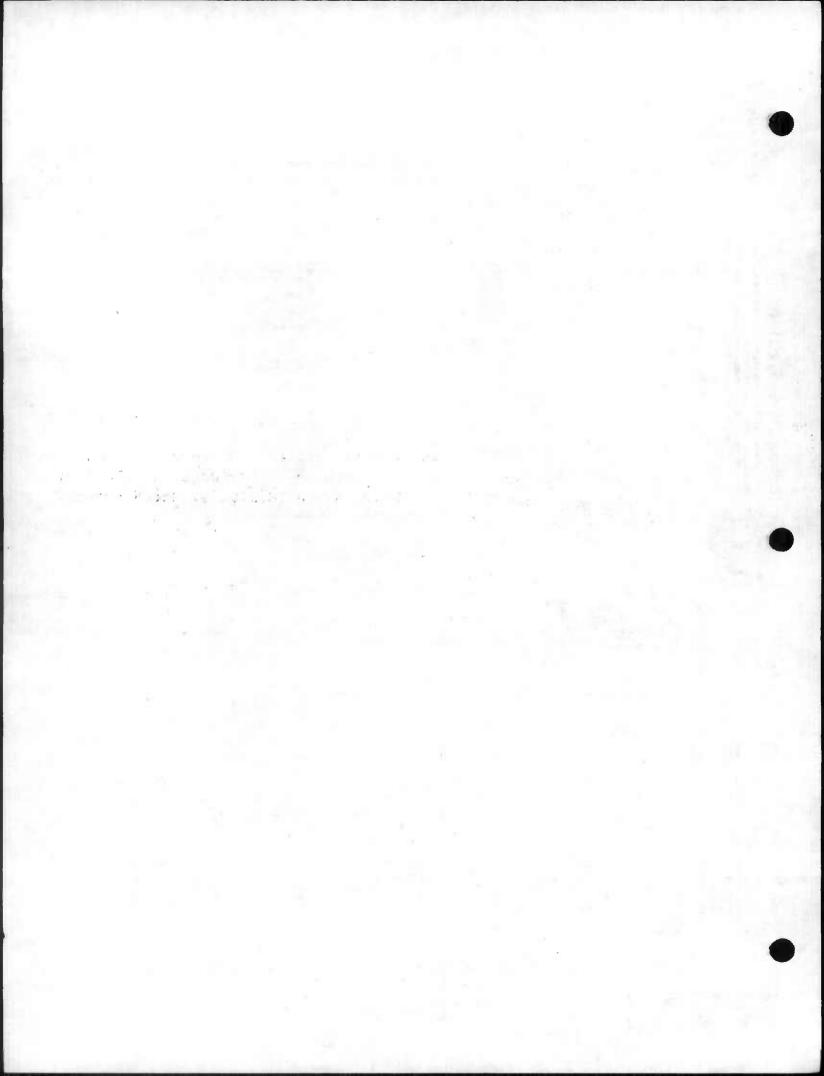
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** Oct. 07, Franklin Matthew Mavne 4:45am /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner 2007 E. 30th Street Baltimore NA If Under 24 Hrs. If Under 1 Year Data of Birth Month, Day, Year) 10-15-15 Birthpiaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F PAnama 215-46-9284A Yrs. Director Usual Rasidance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at MD NA Baltimore XTX Yas 2 No Director 288-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or Berrie 23a or 2007 East 30th Street 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarlo Rican, atc.) Was Decedant Evar in U,S. Armed Forcas? 1 Yes 2 No If Yas, Giva 14. Race - Amarican Indian, Black, Whita, atc. hours after 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black à 3 Widowed 4 Divorced natural. Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Collega (1-4or 5+) Donohoe Construction 10th Grade NA Construction Worker 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Meiden Sumeme) Be Department of Health and Mental reportant: If Item 27 is marked or Pages 1 and 2 should be Balfour 2 Thomas Mayne Hannah 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. informant's Name/Ralationship (Type, Print) 2007 East 30th Street Baltimore, MD. Mayne 20b. Place of Disposition (Name of cematary, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata ₩ Burial 2 Cramation 3 Removal from State Loudon Park Cemetery 10-12-99 Baltimore, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licensea 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue 23a. Parti. Enter the disease, of do shock, or heart failure. List er Approximate Interval Between Onset and Death tha daath. Do not enter tha moda of dying, such es cardiac or respiretory errest, **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in death) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaesa or injury that initiated events rasulting in death) Last Box 68760 Physician/Medical as a consequence of 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 2 3 Probably 4 Unknown be det Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No certificate Division of Vital or Attending Physician: 25. Was case rafarre no medical Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 1 Yas 2 No Medical Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 5 Rasidence 6 Other (Specify) this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Natural 2 Accidant 5 Panding 1 ☐ Yes 2 ☐ No death. invastigation after deat Director: 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 24 hours s Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signatura and fitla of certified 29c. License number 29d. Date signed (Month, Day, Year) 10-11-99 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)

ISSAM E CHELKH, MD 201 EUNIVERSITY PKWY BALTO 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

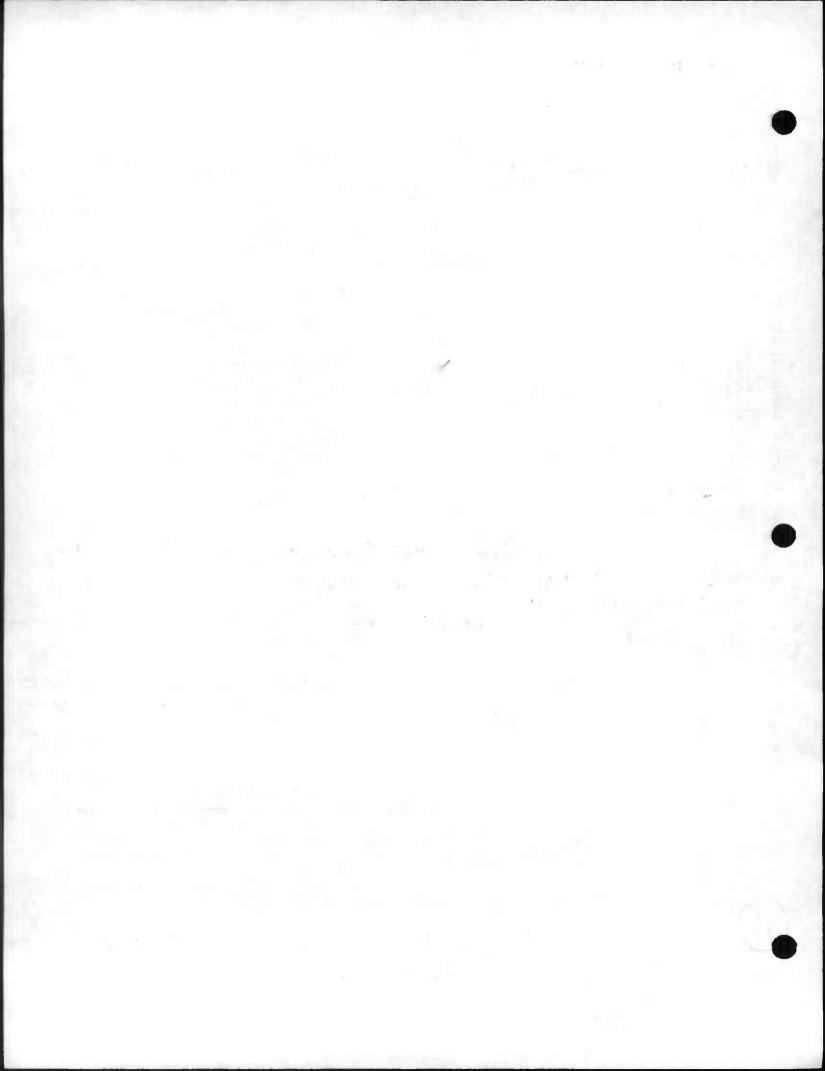
DHMH 16 Rev 6/95

Registrar



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/Medical	4a Facility Name (If not institution,				4b. City. Tow	n, or Location of Dea			10 Pin			
Examiner		Dalewood R	md			onium		timore				
Eumoral			(In yrs. last birthda	y) If Under 1 Ye	ear If Under 2	Hrs. 8. Date of Bi		9. Birthplace (S Country)	State or Foreign			
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be notified Director	10e. Street and Number			10f. Zip Cod	le		10g. Citizen of W	/hat Country?				
al D	8660	Hoerner A	venue		21234		Unit	ed Stat	tes			
r Hema 23a Inverment Funeral	11. Marital Status	12. Wes Decedent Ev Armed Forces?	er in U,S.	3. Wes Decedent	of Hispanic Origi	n? (Specify Yes or N Puerto Rican, etc.)	0- 14. Race	- American Ind k, White, etc.	ian,			
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r, the Medical Exp.	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	cedent's Usual Oc ve kind of work do	cupetion	of working	16b. Kind of Bu	siness/Industry				
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Be	17. Father's Name (First, Middle, La					s Name (First, Middle		e)				
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any injury or other traumatic avant, the Beones. To Be Comp	19a. Informant's Neme/Relationship			The state of the s		or Rural Route Numb						
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2	4 Donation 5 Other (Spe		Green M	ount Cr	ematory	10/7/99	Baltin	nore, Mo	aryland			
트립	21. Signeture of Funeral Service Lic	censee		22. Name and Ad	dress of Facility	,	0.4					
any i	Laura Christines	Hardento		CAFA S	stephen D	Lohrman	P.A.		2 12 8/.			
	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approx											
cian	shock, or heart failure. List or	nly one cause on each line.						Intarv	at Batween t and Death			
ical	Immediate Cause (Final											
iner	thmediate Cause (Final disease or condition resulting in death) a. Com A walk Cancer OVARy with Mels Dua to (or as a consequence of):											
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dical Examiner	Sequentially list conditions	b	ua to (or es a cons	sequence of:				!	111			
m X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	11	0.	01				0.5	2 11			
Ca	that inflated events	C	e to (or as a cons	equence of):					7.2.0			
slan/Med	resulting in death) Last							t				
2	•	d										
Physician/Med	Part II. Other significant conditions	contributing to deeth but	not resulting in the	underlying cause	niven in Part I	23b. Dio	tobacco use cor	se contribute to the cause of death?				
hys			tributing to deeth but not resulting in the underlying ceuse given in Part I.									
	1□ Yes 2☑No											
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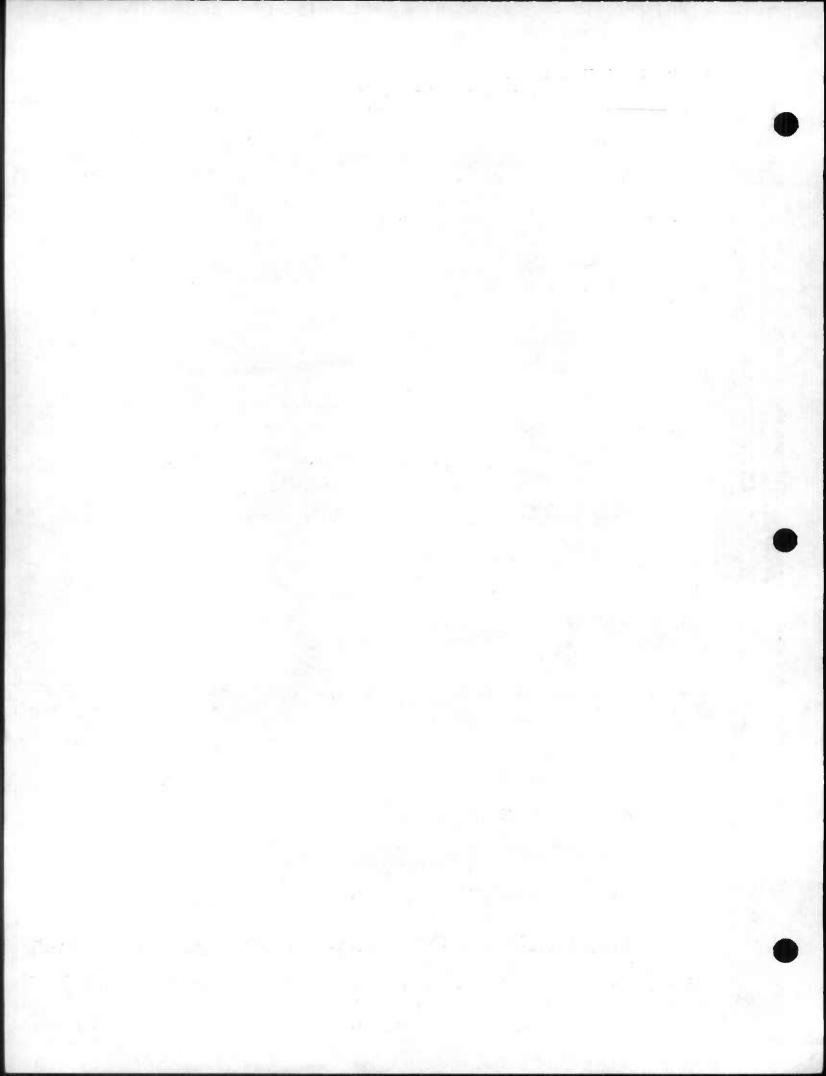


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		ocurity Number	er 6. S	Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under 24			Birth Day, Year)		9. Birthple	ace (Stata o	r Foreig
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DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** October 11, 1999 7:38AM MCKEE). EDWARD /Medical 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A Good Samaritan Hospital 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth 09/10/1915 9. Birthplaca (Stata or Foreign **Funeral** Months 100 M 2□ F Days Hours 213-10-6514 Yrs. MaryTand Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 United States 5525 Sefton Avenue Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 [A] Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2☑ No Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Newspaper (Baltimore Sun) Art Director 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Lottie Pfieffer Edward J. McKee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 5525 Sefton Avenue, Baltimore, Maryland 21214 19e. Informant's Name/Relationship (Type, Pnint) Mrs. Elean R. McKee/Wife 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. Placa of Disposition (Name of cematery, crematory or other place)
Gardens of Faith. Cemetery Date 20c. Location - City or Town, State 10/14/1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21. Signature of Funeral Service Licansee Christina L. David 21214 Mishna L. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA 3 WEEKS Examiner Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical the t Due to (or as a consequenca of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4₽ Unknown DIABETES MELLITUS þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy DAY CONGUENE RIGHT FOOT performed' hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No ospital or Attending Physician: Thours after death.
Inversit Director: After this certificat if filled in by the funeral director, pe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ PA/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Hatural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 627394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SGOL LOCH RAVEN BLUS TOS BALTMONE, MD 21239

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

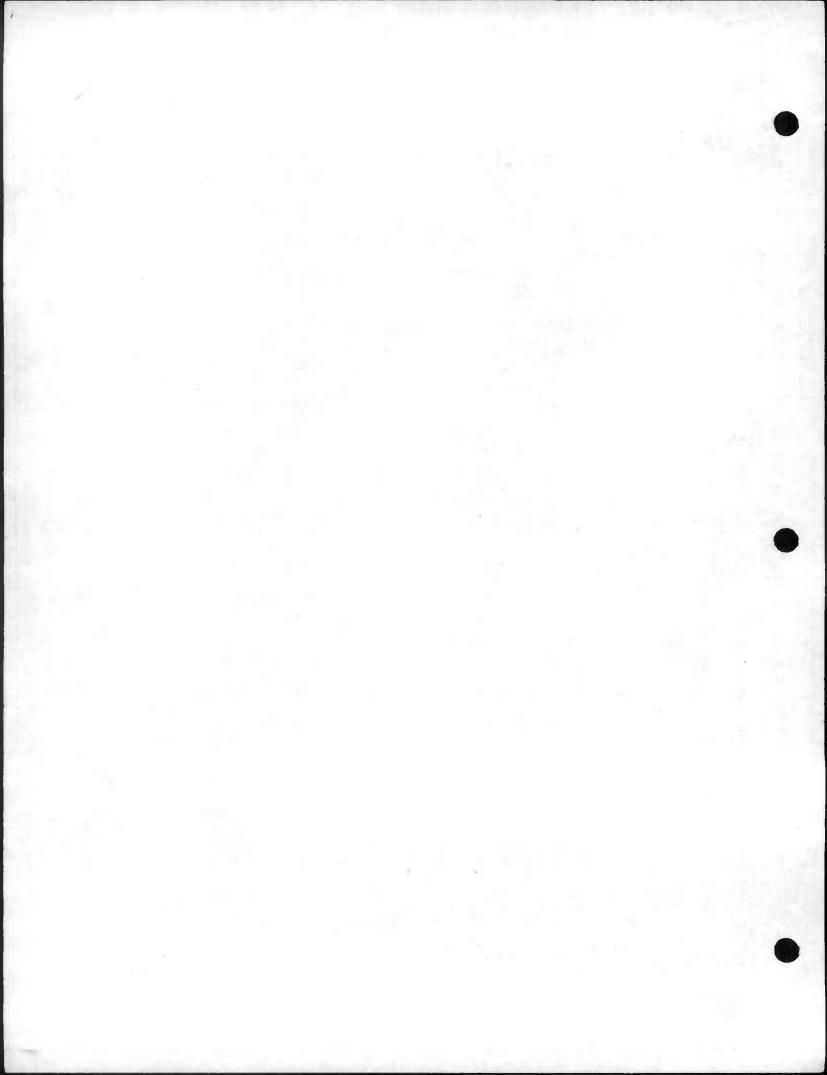
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32. Registrar's Signature

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	Morris	TEMC #00 DADE	State of M	aryland / Depa	artment of I	lealth and N	fental Hyg	liene 9	3	128	
A		TEMS: #23 PART 1. Decedent's Name (First, Middle, Las		R MEO CE	illicate of	Death	2. Date of Dea	th		3. Time of Death	
	Physician /Medical		Glenn C	ole Morris			Month Octobe	r 4, 19	Year 99	12:44 p.	
	Examiner	4a Facility Name (If not institution, give				4b. City, Town, or L		4c. County			
		7735 B&A Boulevar 5. Social Security Number 6. So		e (In yrs. last birthday)	If Under 1 Year	Glen Bur			Arund		
	Funeral Director		23.M 2□ F	38 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day June 21			ce (State or Foreign y) yland	
Amend	B 18	10a. State 10b. County		10c. City, Town or Lo	ocation				10d	I. Inside City Limits	
Ih the Maryland	dilled.	Maryland Anne Ar	undel	Glen Bu	rnie					1 ☐ Yes 2X No	
th with th	_4 —	10e. Street and Number 7735 B & A Boule	evard		10f. Zip Code 2106	50		Og. Citizen of V	•	n	
21215-0020 d within 72 hours after designens. or then "natural", or herre	at, or home 23s Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 SDivorced	12. Was Decedent Armed Forces? 1 Yes 2 4 If Yes, Give Year or Dates:	No	Was Decedent of I If Yes, specify Cub 1□ Yes 2☑No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc. Specify: White			
	ygiene. ser than "natur nt, the Medical. Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give		during most of work d)		16b. Kind of Business/Industry			
D 2	INT M	12th 17. Father's Name (First, Middle, Last)		Mac	chinist /	Pipefitt 18. Mother's Nam		Constr Maiden Suman			
Maryland	Mental H srked off affic even To Be	Robert V. Morris Sr. Florence T. Tembush									
	ls me	19a. Informant's Name/Relationship (7				and Number or Rur		_			
	Health Am 27 Ahar t	Robert Morris Jr 20a. Method of Disposition	• / Broth	er 9219	Curtis I	Orive (Columbia	, Maryl 20c. Location -			
E S	ment of tent: If its lury or o	1 Burial 2 XCremation 3 4 Donation 5 Other (Specify		Hilltop	matory or other pla		.0/7/99	Towson			
Ball	Departimport any in ansa	21. Signatusa of Funeral Service Licen	ramiro		2. Name and Addre	ess of Facility nie Highwa	Gonce F y Balt				
		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	lications that caused ne cause on each li	I the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory an	rest,	lr Ir	pproximate nterval Between Onset and Death	
40	ysician Medical	Immediate Cause (Final	CE.	IZURE DIS	ODDED					niset and Death	
E	caminer	disease or condition resulting in death)	aOE.	Due to (or as a conse					1		
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8760, cate be execut	physician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underdying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):									
ords, P.O. Box 68760, requires that the death certificate be associated		resulting in death) Last	1								
death	d by the stranding etached for use a Physician/M	Part II. Other significant conditions co	entributing to death b	ut not resulting in the u	nderlying cause gi	ven in Part I.	23b. Did tobacco use contribute to the cause of death				
het the de		CHRONIC ALCOH	OL USE				1 Yes 2 No 3 Probably 4 Unknown				
Records,	should bluods						24a. Was a perfor		avail	autopsy findings able prior to pletion of cause ath?	
	page 2						2 DY	es 2 No	V	Yes 2 No	
	certificate rector, page Be Co	25. Was case referred to medical examiner?			× 1	26. Place of Deat	th (Check only or	16)			
of VIta Physician:	ral dire	1)(C) Yes 2 □ No 27. Manner of Death	Hospitat:		H de son		ome 5 KResid 28d. Describe h				
Vision	ation	1 Naturat 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da)	Year) Injury	Wo	rk? Yes 2□No	200. 000010011	ow injury coop.	.00		
5 8	ns after death. al Director: After t led in by the funer. Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, etc.	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Tow		per or Rural F	Route Number,	
To the Hospital	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Phy (Check only one) Medical Exam	rsician: To the best of iner: On the basis of and manner sta	of my knowledge, deat examination and/or in sted.	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, c	ause(s) and ma late and place,	anner as stat and due to th	ed. ne cause(s)	
Toth	To the	29b. Signature and the of certifier	10	10	29c. Licens	se number	2	9d. Date signe	d (Month, De	ay, Year)	
		1/1 am	- Cokell	N)	0.C	.M.E.		October	5, 1	999	
		(MARCA)	ompleted cause of d	eath (Item 23a) (Type,		t, Baltim	ore, Mar	yland 2	21201		
	State Registrar	31. Date filed (Month, Day, Year)	1999 Negistr	r's Signature	1. 100	relist					

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) Date of Death Month 3. Time of Death Year Physician Anita Marano 1999 October 10. 4:10 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore Hours Min. 8. Date of Birth (Month, Day Year)
May 19, 1905 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 94 Yrs. Birthplace (State or Foreign Country) 6 Sax **Funeral** Days 213-20-4956 1 M 2X) F Director Sicily, Italy Usual Residence of Decedent the Marylend permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentai Hygiena. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show way injury or other traumatic event, the Mexical Examination must be notified at Page. 10b. County 10c. City, Town or Location 10d. Insida City Limits MD N/A 1 Yas 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5309 Remmell Ave. 21206 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yas 2XNo If Yas, Give Year or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Ownhome 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) 8 Joseph Giarrizzo 0 Maria Di Martino 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Relationship (Type, Print) Mr. Robert A. Marano / Son 8 Valley Hi Court Lutherville MD 21093 20b. Place of Disposition (Nama of 20a. Method of Disposition Data 20c. Location - City or Town, Stata Gardens OF Faith 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/13/99 Baltimore, MD 4 Donation 5 Other (Specify) Entombment 21. Signature of Funeral Service Licensee Deffrey L. Gain 22 Nama and Address of Facility Ruck Towson Funeral Home Inc. an 1050 York Rd. Towson MD 21204 e, or complications that ceused the death. Do not entar the mode of dying, such es cardiac or respiratory errast, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Approximeta Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner iclan and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician at the buriel Box 68760. Physician/Medical that initiated events resulting in death) Last Dua to (or as a consequence of): for use signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yaa 2 No þ 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 has 2 NO 20 No 1 TYas 1 Yes certificate or Attending Physician: funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Laursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thia 27. Manner of Death 28b. Time of Injury 28a. Data of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yas 2 No within 24 hours after deeth. To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only the 29b Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 7672 Belair Rd MICHAEL D MARTIN,

DHMH 16 Rev 6/95

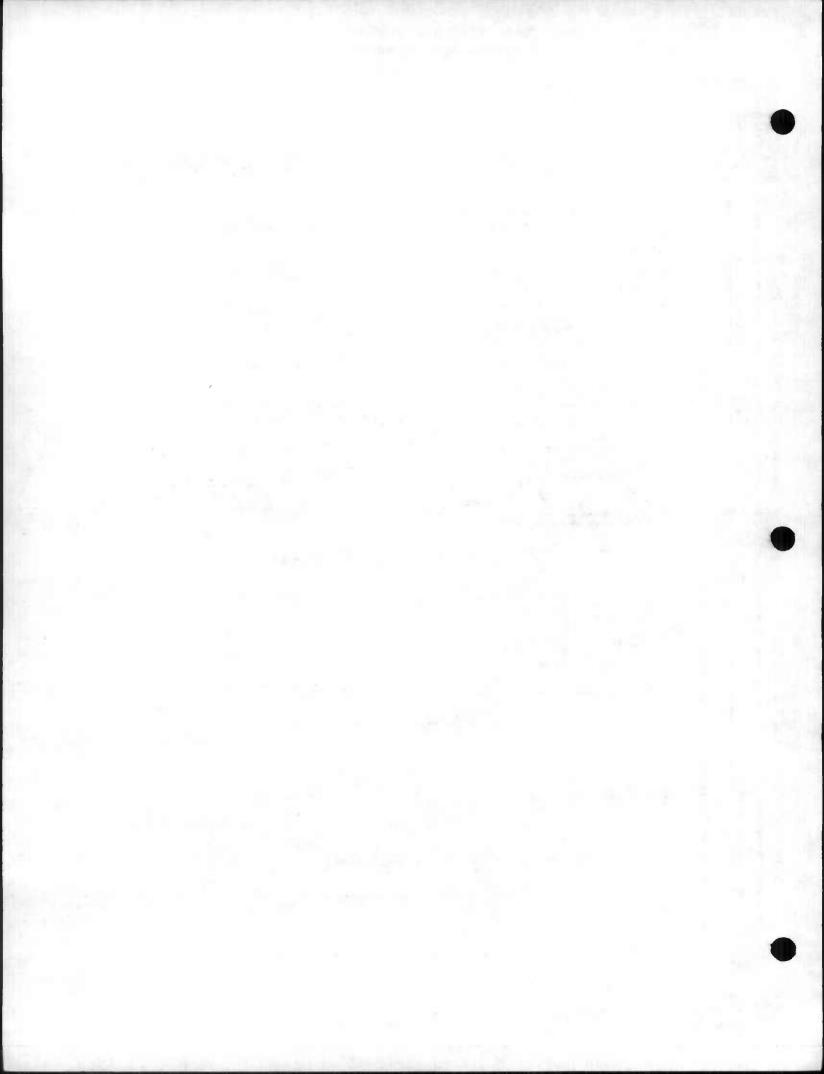
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Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Way Musgrave October /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death maryland 4c County of Deeth Examiner university 130 Itimore paltimore (0 } If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. 5ex 7. Age (fn yrs. last birthday) 6. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 15 M 2□ F 502.03.2510 81 Yes Dec. 1, 1917 North Dakota Director Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD BALTIMORE 1 ☐ Yes 2√ No N/A Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4011 Bay Drive 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give WW I I Year or Detes.WW I I 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marifal Status 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat eny hijury or other traumatic event, the Medica page. Elementery/Secondary (0-12) College (1-4or 5+) Automobile Mechanic Mechanic 12 17. Father's Nema (First, Middle, Last) 18 Mother's Neme (First, Middle, Maiden Sumame) Be Thomas Musgrave Anna Beaumaster 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Russell Musgrave/Son Overbrook Rd. Catonsville, Md. 21228 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete XXBurial 2 Cremetion 3 Removel from Stete Lakeview Cemetery 10/14 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab 21. Signeture of Funeral Service Lie 411 736 Edmondson Ave. Catonsville, Md.21228 Wo Enter the disease, or complications that caused the daath. Do not entar the mode of dying, such as cardiac or respiratory errest, or heer failure. List only one cause on each line. Approximeta Interval Betw Onset and Death **Physician** cord injury Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Examine physicien and the burief-transit that the death certificate be executed CENTRICATION APPRIOUSED BY WEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury Box 68760 Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of): USB P.O. Pert If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? none 1 | Yee 2 No 3 | Probably 4 | Unknown of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24e. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Placa of Deeth (Check only one) Yes 2□ No Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) edical Certification: To 1√ Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Tima of After Division or Attending 6119 PM 5 Panding investigation 1 Natural after death.

Director: Aft
d in by the fur felloff deck October 02,1999 1 Yes 2 No 20 FRET 2 Accident 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Joppatowne, Mr Home 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, deta end pleca, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fitle of certifier H 55103 12.0. 30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)

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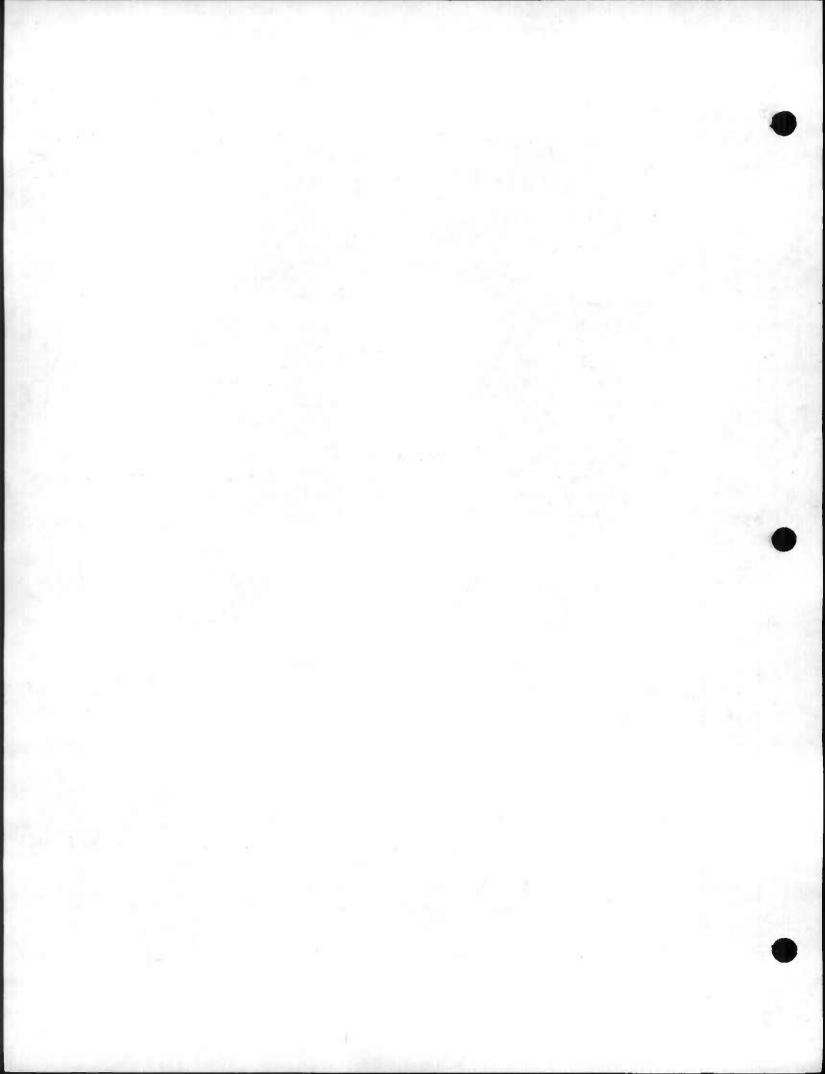
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31. Dete filed (Month, Day, Year)

S. Greene

32. Registrar's Signature

Shock Trauna Cuter



Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

x 28a-f show

item 27 is marked other than "naturel", or items 23e or other traumatic event, the Medical Examinar must be a

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "re any injury or other traumatic event," in a fired.

Director Md

Funeral

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Completed

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Examiner esn Certification: To

physician the á bengis be dat peed page 2 has certificate funeral To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera After

Records,

Division of Vital

Physician/Medical by Completed Be 27. Nanpel of D

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

No

1 ☐ Yes

Natura/

2 Accident

3 Suicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier 29b. Signature end title d

5 Pending

Investigation 6 Could not be determined

> Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
>
> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dey,

28e. Dete of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Time of

32. Registrat's Signeture

28c. Injury et Work?

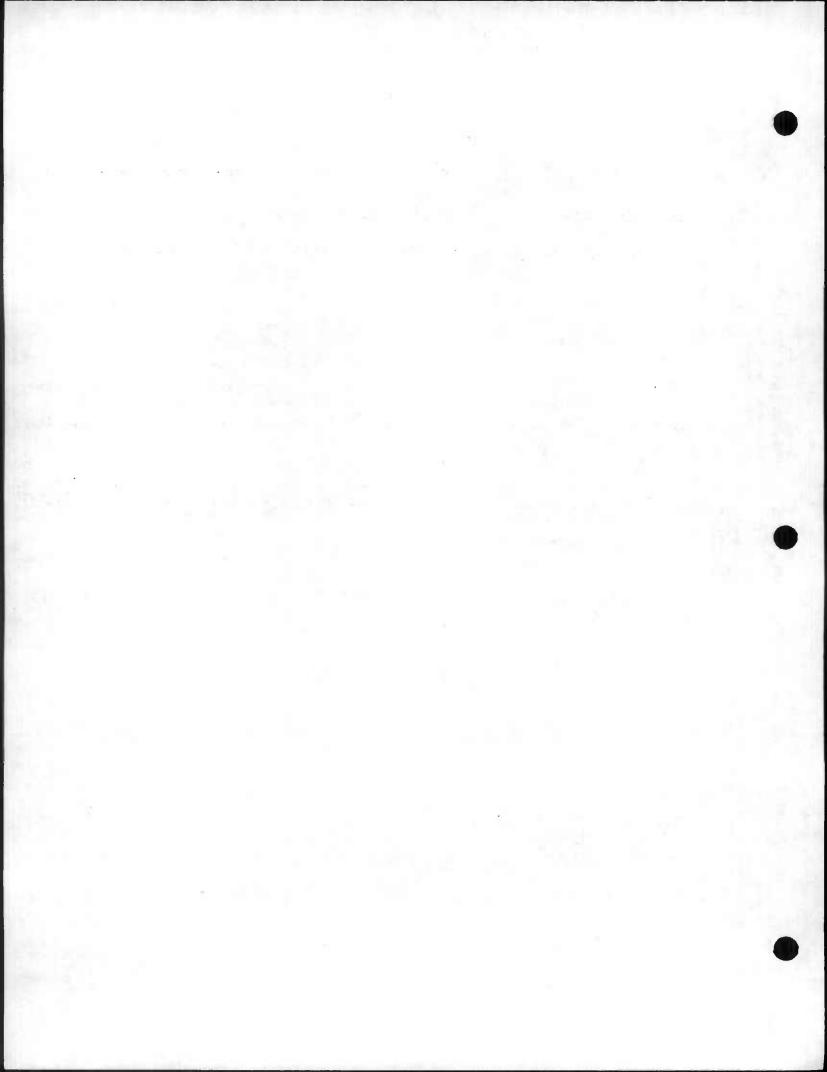
1 ☐ Yes 2 ☐ No

State Registrar

Transfer strate

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician Month DETOBER 4 1999 15:22 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL SYSTEM BAltimORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 12 M 2 F 212-58-0641 Director VOV. 02, 1951 MARYLAND Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE MARYLAND Director 288-4 must be notifi 10e Street and Number 10f. Zio Code 10g. Citizen of Whet Country? or harns 23s or PLACE, APT 1701 EUTAW Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever In U,S. Armed Forces? 11 Meritel Stetus 14. Race - American Indien, Bleck, White, etc. Never Merried 2 Merried 1 ☐ Yes 2 ☒ If Yes, Give Yeer or Detes: 2 No altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) ğ College (1-4or 5+) UNEMPLOYED 17. Fether's Neme (First, Middle, Last) 8. Mother's Neme (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 aboutd be Department of Health and Mental Important: if from 27 is marked of ARCHIE 2 ERNESTINE MUERS 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 80 1 CLAY BROOKE DRIVE, BALTIHORE, MD 21244
Disposition (Name of) Dete 20c. Location - City or Town, State RNESTINE WASHINGTON MOTHER 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MARULAND NATIONAL LAUREL MARYLAND 22. Name and Address of Facility BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217 21. Signeture of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the feeth. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediete Cause (Finel Adult Respiratory Distruss diseese or condition resulting in deeth) 22 days Examiner Due to (or es a consequence of): Endo coudita's Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): that the death certificate be execu Box 68760 HIV Physician/Medical Due to (or es e consequence of): P.O. Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Dfd tobacco use contribute to the cause of deeth? signed by t 1 Yaa 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? ...ospital or Attending Physician: Th. Yin 24 hours after death.
Ye Funeral Director: After this Attentified in by the Attention of the Attent 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 1 Neturel 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) and menner as steted. sompletely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner stated. the th e di 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 Mobashere 133 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) Greene St. Baltimore m021201 N. MOBASHERY umms 31. Dete filed (Month, Day, Year) 32. Registrac's Signeture State OCT 12 Registrar

DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Middendor 5, 1999 4c. County of Death Creorge 0800 October /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner H Under 24 Hrs. B. Dette of Birth (Month, Day, Year JAN 2, 1916 Hop kins Bayview Bellinne JOHNS 7. Aga (In yrs. last birthday) If Under 1 Year Months Days 6. Sex Birthplace (Stata or Foreign Country) 5. Social Security Number **Funeral** 217-12-6540 1X M 2 ☐ F 83 Director Maryland Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits worde ! r than "natural", or Nems 23a or 28a-1 sho the Medical Examinar must be notified at N/A Baltimore 1 XYas 2 No Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 3425 Esther Place 21224 USA deeth 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mentel Hygiene. Innportant: if them 27 is marked other than "natural", or frem any injury or other treumatic event, the Medical Pages. Black, White, etc. 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: à 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baker Baking Company 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Harry Middendorf Jennie Unk. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Lawrence Middendorf/son 3524 Oxwed Ct. Westminster, MD 21157 Data 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata Metro Crematory, Inc. 10/06/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Thomas De Cremation Society of Maryland, Inc. Thomas Gregor | 299 Frederick Rd. Balti: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21228 299 Frederick Rd. Baltimore, MD Approximala Intarval Batween Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical Cardiopulmoras Examiner Due to (or as a consequence of): Physician/Medical Examiner Myorardia ettending physician and for use as the buriel-transit The lew requires that the desth certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of) 68760 that initiated events resulting in death) Last Dua to (or as a consequence of): Box P.O. | 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. been signed by the should be detached 1 No 3 Probably 4 Unknown Division of Vitai Records, à cata has been significant page 2 should b 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yas 2 No 1 Yes 2 No Hospital or Attanding Physician: 24 hours after death. Furnerel Director: After this certification in the funeral director; [25. Was casa rafarred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 2 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funerel C completely filled Certifying Physician: To the best of my knowledge, death occurred et the tima, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certifier 29c. License number

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, Year)

of person who completed causa of death (Item 23a) (Type, Print)

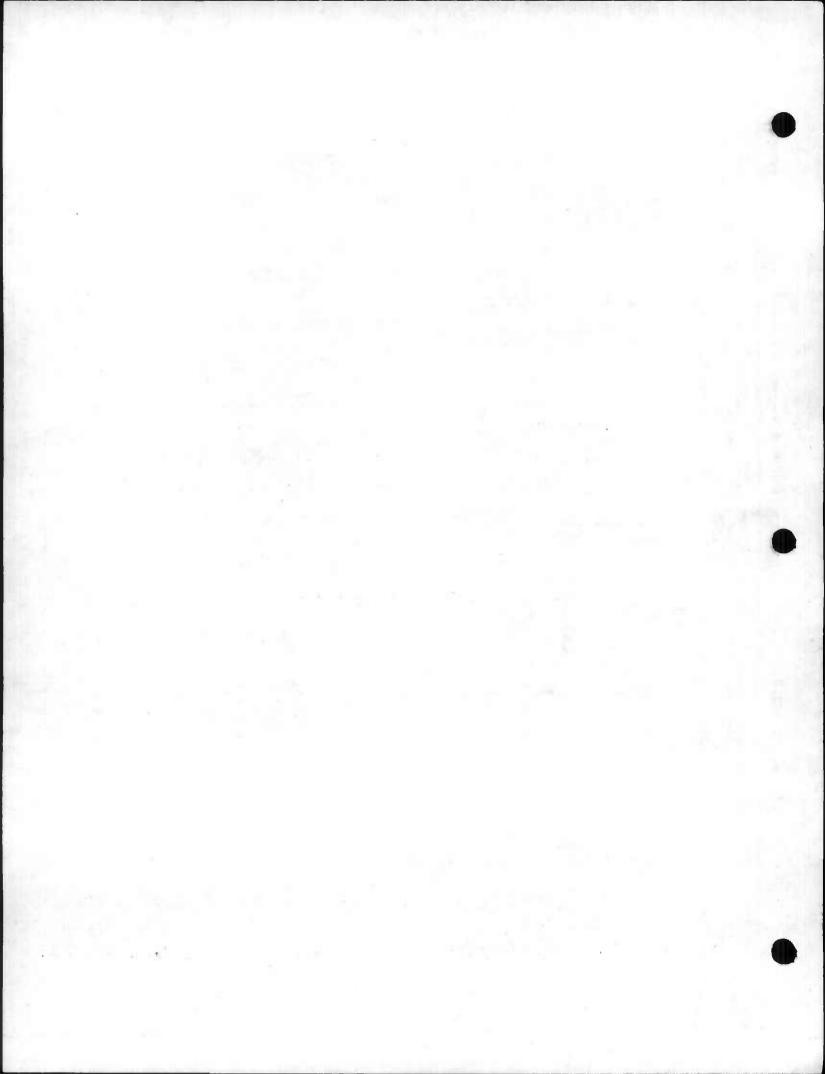
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32. Registrar's Signatura

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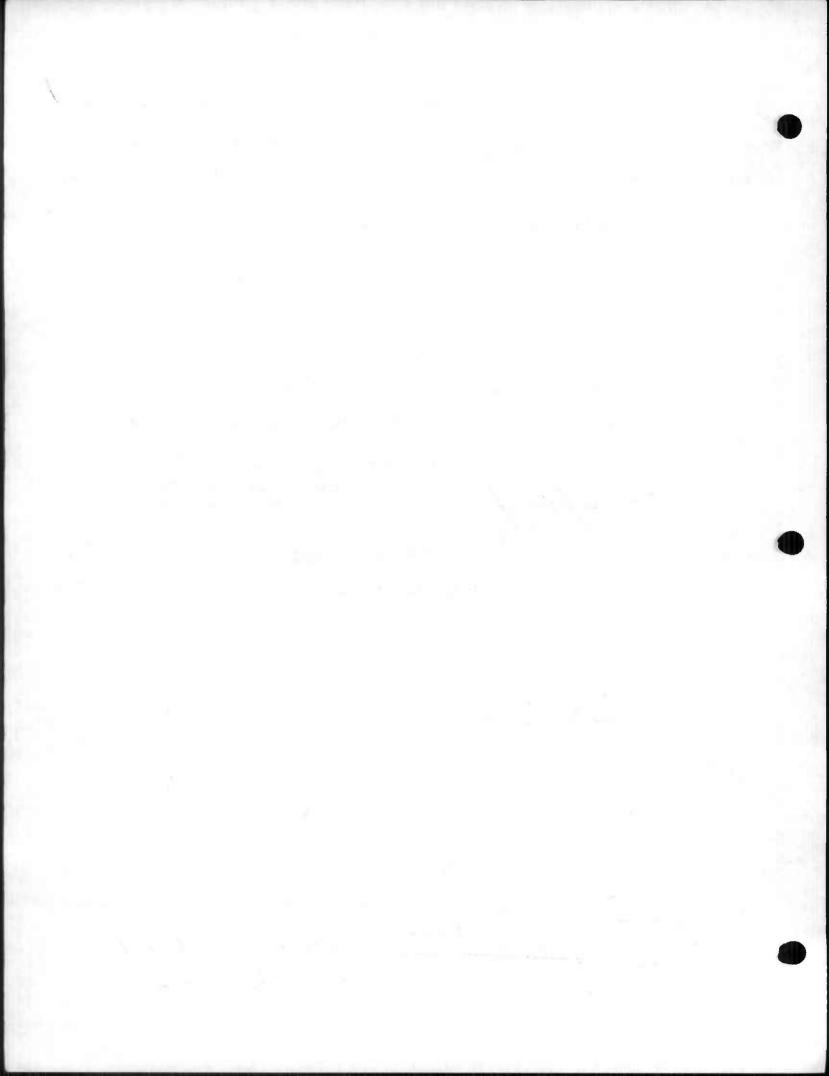
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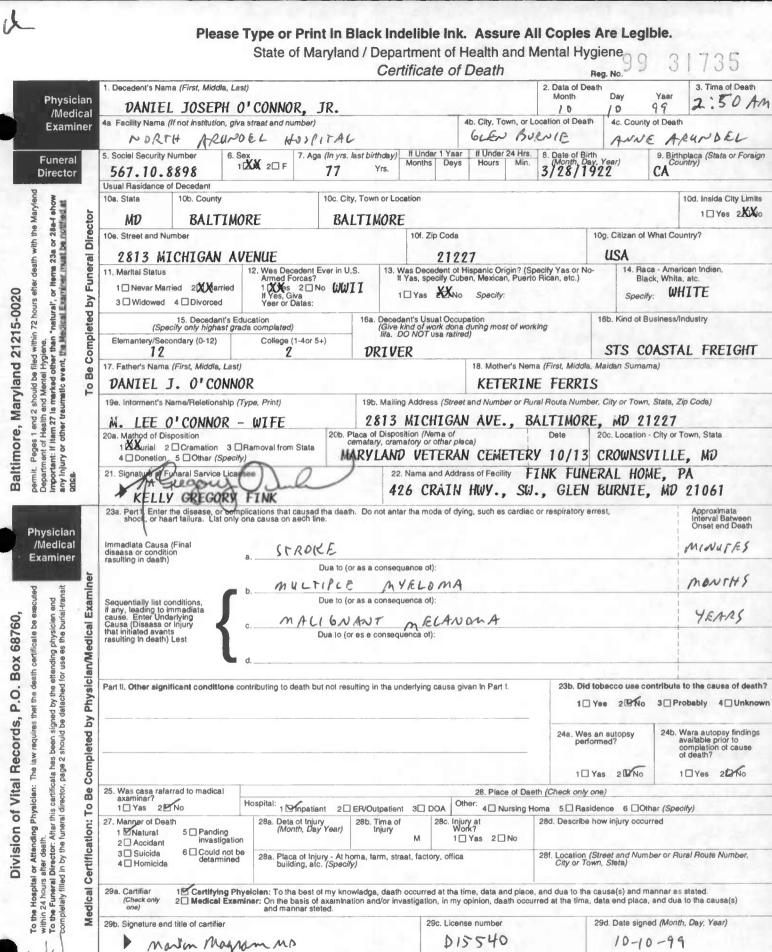
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			Certificate of Death		Reg. No. 99	31734			
	Dhamini	-	Decedent's Name (First, Middle, Last)	2. Dete of D	eath	3. Time of Death			
	Physici /Medio		SALLY HAYES NICHOLS	0ctobe	er 8,1999 Y	3:00 PM			
	Examir	ner	4a. Fecility Neme (If not institution, give street end number) 4b. City, To	wn, or Location of Dee	th 4c. County of	Death			
				erville	Baltin				
1	Funeral Director		1 M 2 F Vrs Months Days Hours	Min. (Month, D	ay, Year)	Birthplace (State or Foreign Country)			
			116-36-8082 A 90 III.	May 31	, 1909	N.J.			
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits			
	the Marylar 28a-f show	ctor	Md. Baltimore Lutherville			1 ☐ Yes 2 🖺 No			
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Who	at Country?			
	ath w	rai	515 Brightfield Rd. 21093		USA				
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orient If Yes, specify Cuban, Mexican	gin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rece - Black,	American Indian, White, etc.			
20	72 hours after death with the Maryland natural', or items 23e or 28e-f show deal Examinet must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No H Yas, Give 1 Yes 2 No Specify: Year or Dates:		Specify:	White			
21215-0020	2 hou	Pa	15. Decadent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busin				
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21	filed within Hygiene. ther than "	Com	12 4 Home maker		Own home				
pu	be file tal Hy d oth	Be (17. Father's Neme (First, Middle, Last) 18. Mother	er's Name (First, Middle	e, <i>Maiden Sum</i> ame)				
yla	S should be filed with and Mental Hygiene. Is marked other than aumatic event, than	To	Wade Hampton Hayes Juli		Yard				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23e or 28a-f show ther traumatic event, the Medical Examiner must be notified as		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number) 19c. Classification of Discourse (Street and Number)						
	1 and 2 Health em 27 I		Mrs. Sheila Trout/daughter 8515 Tallwood Rd.	Date	20c. Location - Cit				
altimore,	00		1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)						
1			4 Donation 5 Other (Specify) Hilltop Service Corp. 21. Signature of Funeral Servica Licensee 22. Name and Address of Facilit	10/11/9		, Md.			
B	permit. Departr Imports any inje		Ruck Towson F						
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. This only one cause on each line.	owson, Md.	21204 arrast,	Approximate			
а	Physician		shock, or haart failure. Ast only one cause on each line.			Intarval Batween Onset end Death			
П	/Medical		Immediate Ceuse (Final disease or contition and disease or contition as the continuous and the continuous an			deis			
н	Examiner	L	rasulting in death) a. Due to (or as a consequence of):						
	bed is	Examiner	Multinifarct Demen	la		Years			
	icate be executed physician and s the burial-transit	xan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying						
68760,	siclar b buri	edical	Cause (Disaase of Injury C.	0.0000000000000000000000000000000000000					
			resulting in deeth) Lest Due to (or as a consequence of):						
Box	death certifi e attending ed for use as	N/UE	d						
	0 0 0	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	. 23b. Die	23b. Did tobacco use contribute to the c				
P.0	requires that the de been signed by the a hould be detached f	Physician/M	Dorte Stenoris	1	Yes 20 No 3	☐ Probably 4 ☐ Unknown			
	igned be d	by	The Otomis						
Records,	v require	Completed			s an autopsy formed?	24b. Ware autopsy findings evailable prior to completion of causa			
3ec	aw 2 s S	mple				of death?			
al	E ag			1 🗆	Yes 20 No	1 ☐ Yes 2 ☐ No			
of Vital	Physiclan: this certific ral director,	Be C	examinar/	of Death (Check only					
	r this	7: To	27. Manner of Death 28a. Data of Injury 28b. Time of 28c. Injury at	rsing Home 5 Res	how injury occurred	(Specify)			
on	Attending In death.	ation	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 ☐ Yes 2 ☐	No					
Division	Attendir or death. octor: A by the fu	iffica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica		(Street and Number	or Rural Route Number,			
Ö	rs afte al Dire	Certification:	4 ☐ Homicida building, etc. (Specify)	Chy of Te	JWII, State)				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Cartiflier (Check only one) Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deal	d placa, and due to the	causa(s) and mann	ar as stated.			
	To the within 2 To the comple	Σ	29c. License number 29c. License number	2	29d. Date signed (Q			
			DI III C		-/4/7				
	10		Jak SchwARtz M.D. 115 E. Melrare	Are 2	1217				
	Sta	te	31. Date filed (Month, Day, Year)- 32. Registrar's Signature	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
		ar	007 12 1999 Drew B. Sparks	*					

DHMH 16 Ray 6/95





1406 B SOUTH CRAIN HIGHWAY SHITE 304 GLEN BURNE, MO 21061

State Registrar 30. Nama and addrass of person who completed cause of daath (itam 23e) (Type, Print)

32. Ragistrar's Signatura

MARTIN MAGRAMMO

OCT 12

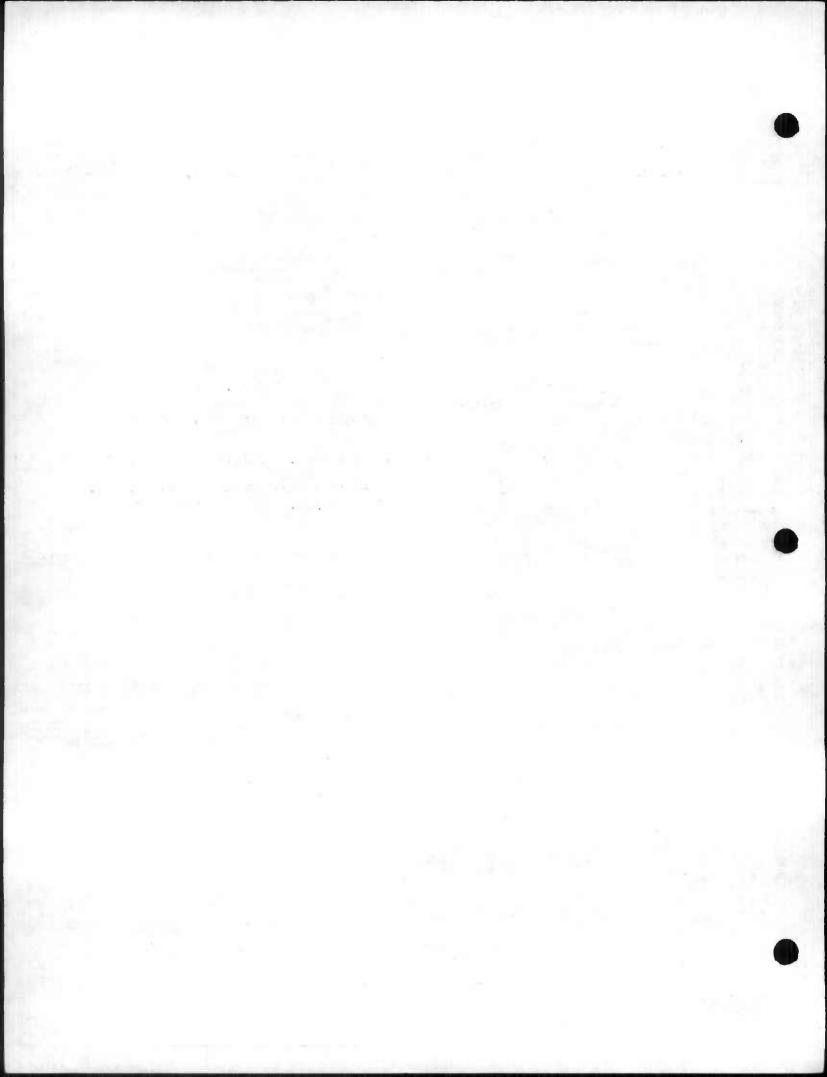
31. Data tilad (Month, Day, Year)



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				epartment of I Certificate of		-	Reg. No.	31736
Physician /Medical	Decedent's Neme (First, Mic	Mar Mar	tha Louise	Oatman		2. Data of Dec Month OCTOBE	Day	Year 999 4.16 P.1
Examiner	4a Facility Name (If not institut FRANKLIN'S	The second secon		CENTER	4b. City, Town, or I			of Death LTINORE
uneral rector	5. Social Security Number 171-07-5890	6. Sex 7 1 □ M 2 🖾 F	7. Aga (In yrs. last birtl 86	nday) If Under 1 Yaar Months Days		(Month, Da	h y. Year) 1,1913	Birthplace (State or Foreig Country) Pennsylvani
	Usual Rasidence of Dacedent 10a. Stata 10b. Coun	•	10c. City, Town	or Location				10d. Inside City Limits
Director	Maryland 10e. Street and Number	Baltimore		10f. Zip Code	Essex		10g. Citizen of V	1 ☐ Yas 2 ☒ No
	1813 Old East	ern Avenue			21221		United	States
Completed by Funeral	11. Meritel Status 1 Never Merried 2 Merited 3 Widowed 4 Divorce	Armed Fore	2∑ No	13. Was Decedent of If Yas, specify Cut 1 ☐ Yes 2 ☒ No		pecify Yes or No o Rican, atc.)	- 14. Raci Blac Specify	e - American Indian, k, Whita, atc. White
-	15. Deced (Specify only high Elementery/Secondary (0-12 12 Years	ent's Education hest grade completed)) Coilege (1-		Decedent's Usual Occu Give kind of work done life. DO NOT use retire Homemake	i during most of wor ad)	king	16b. Kind of Bu	siness/Industry
-	17. Fathar's Nama (First, Middl	e, Last)		nomemake	18. Mother's Nen	ne (First, Middle,	47.7.2.2	
	David Oscar		nighter 10b	Mailing Addrass (Stree		e F. Ba	<i>y</i> <u>1</u>	State Tie Codel
	Barbara Jane			702 Melbour				
	20e. Mathod ol Disposition 1 Burial 2X Cremation 4 Donetion 5 Other		tata cem <i>eter</i>	Disposition (Name of crematory or other place) Disposition (Name of crematory or other place) Disposition (Name of crematory or other place)		Date /13/99		City or Town, State
Completed by Physician/Medical Examiner	23a. Pert1. Enter the disaasa, shock, or haert leitura. Li Immediata Causa (Final diseasa or condition rasulting in death) Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disease or injury thet initiated evants rasulting in death) Last Part II. Other significant conditions.	a. SEV.	Dua to (or as a co	LDIAL Consequence of): Disequence of):	AVE. Duing, such es cardiac	andalk, or respiratory as	Maryland	Approximate Interval Between Onset and Death 5 YEARS
by Phy	CONGRSTION FICIENCY, D	UR HEART	T FAILURE	RENAL	INSUF	10	Yes 210-16	3 Probably 4 Unknow
	FICIENCY, D	IABETES		1404	BOW CANO		an autopsy rmed?	24b. Wara autopsy findings evailable prior to completion of cause of death?
	HIP FR. 25. Was casa refarred to medicaxaminar? 1 Yas 2 No	Mannitel . 4	patiant 2□ER/Out	patient 3 DOA	her	ath (Check only of loma 5 Resident	one)	1 ☐ Yas 2 ☐ No er (Specify)
	3 Suicida 6 Coul	stigetion d not be		ury Wo	Yas 2□No		how Injury occur Street and Numb vn, State)	eer or Rural Route Number,
edical Certification:		ring Physician: To the bal Examiner: On the bes	sis of axamination and					
	29p. Signature and title of certif	Luns,	of deeth (item 23a) (1	ype, Print)	5 4 76	7	29d. Data signe	d (Month, Day, Year)
State	DR. DAULD LL 31. Data filed (Month, Day, Yea	8 1999 X	9000 FR. gistrar's Signatura	G. Span	QU ARE	DR. B	ALTO	(10 21237

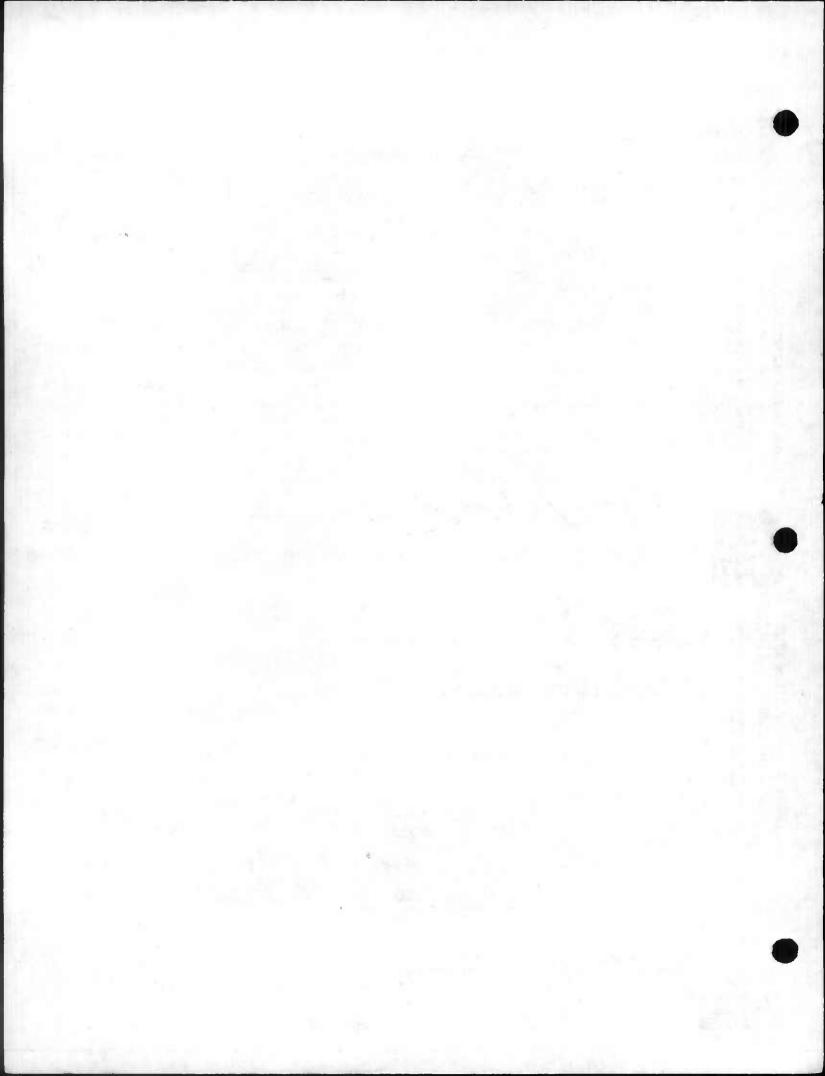
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WRC 99-5975-510 SYLVIA M.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

PINKNEY		State of Mar		epartme Certifica				giene Reg. No. 9	3	1737
Physician	1. Decedent's Neme (First, Middle, La Sylvia Mae	Pinkney					2. Data of De Month OCTOBE		999	3. Tima of Death
/Medica	by I v I d I i d c					6b. City, Town, or L				12:00 PM.
Examine	619 N. BELNORI					BALTIM		NA NA		
Funeral Director	5. Social Security Number 6. 3 218-44-9323		In yrs. last birthd Yrs	Month	lar 1 Yaar s Days	If Undar 24 Hrs. Hours Min.	8. Data of Bir (Month, Da 12-1:		Coun	lace (State or Foreign http://
8 8 w	Usual Rasidence of Decedent 10a. Stata 10b. County	1	Oc. City, Town o	r Location					1	0d. tnside City Limits
Many Many	MD NA		Balti	more						Yas 2□No
th with the Maryland 23s or 28s-f show sat be notified at		d Avenue	-00		Zip Coda 2120	5		10g. Citizen of USA	What Coun	try?
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiens. T'le marked other than "natural", or fams 23s or 28s-f show troumatic event, the Medical Examiner must be notified at TO Be Commissed by Europeal Dispersion	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Giva Year or Dates:	er in U,S.		edent of Hoecify Cube	lispante Origin? (Sp an, Maxican, Puarte Specify:	ecify Yas or No Rican, atc.)		ck, White, over Bla	atc.
72 h	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	cedent's Us	ual Occup	ation during most of work	ring	16b. Kind of B	usiness/ind	Justry
I 21215-0 led within 72 ho typiere. we then 'neturi it, the Medical	Elementary/Secondary (0-12)	College (1-4or 5+)		bore		3)		Baltin	nore	City Sch
and 2	17. Father's Nema (First, Middle, Last)				18. Mothar's Nam	e (First, Middle			
aryla should the marks marks	Edward Wyo					Edna		Wyche		
Mail nd 2 sh alth and 27 is m	19a. Informant's Name/Retationship	/		_		and Number or Au ord Aver				
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Pages natt if he	Donation 5 Other (Speci		Balti	more			-12-9	9 Bal	timor	ce, MD
Baltimore, permit. Pages 1 a Department of Hea Important if Nem any Injury or othe angle.	21. Signature of Funerat Service Lice	nseey &				ss of Facility Ba				nd 21202 nue
Physician /Medical Examiner	Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata	b	clerotic e to (or as a con e to (or as a con	sequence o	f):	scular Di	sease		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
cata be cata be physicis the bu	Cause (Disease or injury that initiated events resulting in death) Last	c	e to (or as a con	sequence of	i):					
P.O. Box (and the death certified by the attending stached for use a Physician M.	Part It. Other significant conditions	contributing to death but r	oct resulting in th	a underlying	causa giv	en in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?
ds, P.O. Box (iras that the death certif signed by the attending d be deteched for use a d by Physician/Me.							10	Yes 2□ No	3 Prot	bably Winknown
requi			L.,				INSP	en autopsy ormed? ECTION	COI	ere autopsy findings allable prior to mpletion of cause death?
	OF Management of the second							Yas 2 No	10	Yas 2□ No
Of Vita Physician: this certific ral director,	1/1 Yas 2 No	Hospital:	2 ER/Outpa	itient 3 🗆	Oth	26. Place of Dea		one) dence 6 □Otl	har (Snacif	(4)
Division of Vital or Attending Physician: T after death. Director: After this certificat in by the funeral director, partification: To Be Co	•	28a. Data of Injury (Month, Day Y	28b. Tim	e of	28c. Injur Wor	y at		how injury occu		,
Division or to the Hospital or Attending Physiphin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:		28e. Place of Injury building, etc. (- At homa, fam, Specify)	, street, fact	ory, office		28f. Location (City or To		ber or Rura	al Route Number,
To the Hospital within 24 hours to the Funeral completely filled	29a. Certifier 1 Certifying Pr (Check only one) 22 Medical Exam	nysician: To the best of miner: On the basis of ax and manner stated	amination and/o	eath occurre r investigation	d et the tir on, in my o	ne, date end place, pinion, deeth occur	end due to the red at the time,	cause(s) end m data end place,	ennar es si and dua to	tha cause(s)
within To the comple		0 (2)		2	9c. Licans			29d. Data signe		
d	Sennis	Chute.	w			O.C.M.E.		OCTOBE	R 06,	1999
4-8	30. Name and address of person who Dennis Chute M. I				Stree	t, Baltim	ore, Ma	ryland	21201	
State	22740	32. Registrar's	Marian Control of the	6	1					
Registrar	00112	1999	was	D	Mar.	Kal				



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DHMH 16 Rev 6/95

State Registrar 30. Nama engladdrass of person who co

31. Data filed (Month, Dey, Year)

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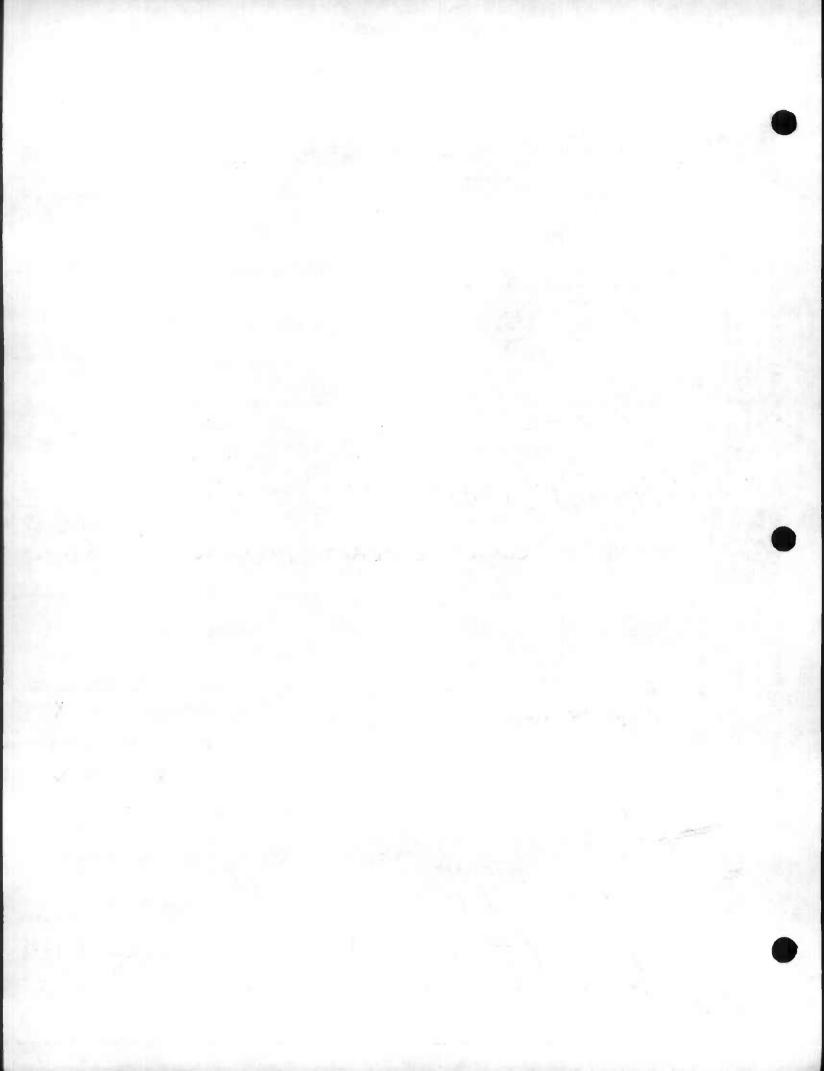
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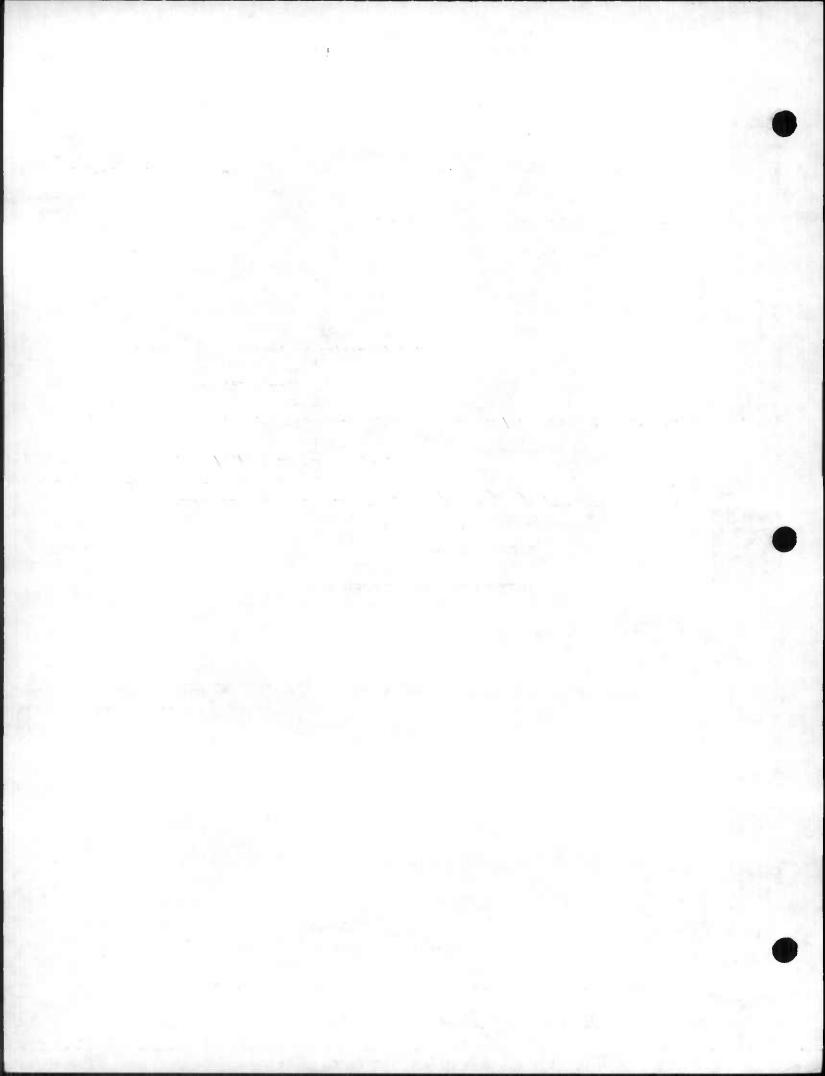
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certifica		Death		Reg. No.	3	1/39
Physician	1. Decedent's Name (First, Middle, Li	est)					2. Date of De Month	ath Day	Year	3. Time of Death
/Medical	Wanda	Panzer					OCTOB	-		10:00 AM
Examiner	4a Facility Name (If not institution, gir	ve street and number)			4	b. City, Town, or	Location of Death	4c. County	of Death	
	Saint Joseph	Medical C	enter			Tows	n	B	alti	more
Funeral Director		Sex 7. Age 1	(In yrs. last birt	hday) If Und Month	der 1 Year s Days	If Under 24 Hrs. Hours Min.	(Month, Da	th y. Year) 0, 1951		ace (Stete or Foreign ny) ginia
death with the Maryland cris 23s or 28s+ show crisual be notified at neral Director	10a. State 10b. County		10c. City, Town	or Location					10	d. Inside City Limits
vith the Ma t or 28s-f s be notified Director	Md. Balt	timore	Т	imoniur	m					1 Yes 2 No
or 21	10e. Street and Number			10f. 2	Zip Code			10g. Citizen of V	Vhat Count	ry?
m miles	2 Tully Cross (Ct.			210	093		Ţ	J.S.A	
_ 1 2 2 2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☑ Note of the Armed Forces?				spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Raci Blac Specify	e - America k, White, e	tc.
72 hours natural; dicat Ex	15. Decedent's E		160	Decedent's Us	eual Occupa	ation		16b, Kind of Bu		
1 21215-0 ad within 72 ho yglere. wr than 'naturn ft, the Medical.	(Specify only highest gr	ade completed)		(Give kind of v	work done of	furing most of wor	rking	100. Kind of bu	ISHIOSSYTTO	ustry
very than	Elementary/Secondary (0-12)	College (1-4or 5+)			Assist		Bank:	ing	
D BEEN O	17. Father's Name (First, Middle, Last	r)	110			18. Mother's Nar				
and the ti	Walter McDonal						a Gilden		-,	
Maryland 21215-0020 02 should be filed within 72 hours at 02 should be filed within 72 hours at 03 and Merital Hyglere. 7 is marked other than "natural", or resumatic event, the Medical Exam To Be Completed by F			405	A de Ula a A data	(01				Otata Tia	Ondel
Mar 32 sh hand hand reum	19a. Informant's Name/Relationship					and Number or Ru				
C = 84 F	Mr. Harvey Panzer	r, Jr./Husb	20b. Place of	Tully		S Ct. T		Marylan		
altimore, Nature of Pages 1 and satmont of Health ortant: If then 27 injury or other talk.	20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter)	, cremetory of	r other plec	θ)	Date	20c. Location -	City or Tov	vn, State
Pag ment ant: 1	4 □ Donation 5 □ Other (Special		Dulan	ey Val	ley Me	em. Grd.	10/11/99	Timoni	ım, M	aryland
Baltimore, permit. Pages 1 at Department of Hea Important: If tem any Injury or othe otics.	21. Signature of Funeral Service Lice	1/2.	21			Road To				ome, Inc.
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	notice on a line transed to	he feath. Do n	ot enter the m	ode of dyin	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
Physician /Medical	Immediate Cause (Final	<i>3</i>								Onset and Death
Examiner	disease or condition resulting in death)	BRAIN D	EHIH						1	18 HRS.
-			due to (or as a c							
olne si		INTERCE	REBRAL	. HEMO	RRHA	GE			ì	
68/60, filtrate be executed g physician and as the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	ue to (or as a c	onsequence o	of):					
2 2 2	that initiated events resulting in death) Last	D	ue to (or as a co	onsequence of	f):					
Box attending for use a clan/M		d							-	
d for d for	Part II. Other significant conditions of	contributing to death but	not resulting In	the underlying	cause give	en in Pert I.	23b. Did	tobacco use cor	ntribute to	the cause of death?
15, P.O. BOX res that the deeth cert rigned by the attending be detached for use a by Physician/M								Yes 2 No		ably 4 ☐ Unknown
COFC requii							24a. Was	an autopsy ormed?	ava	re sutopsy findings ilable prior to apletion of cause leath?
Re les age 2 omp							10	Yes 200 No	1 🗆	Yes 2 No
	25. Was case referred to medical					26 Place of Dec	eth (Check only o	nel		
of Vita Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Out	patient 3 1	Othi	Mr.		dence 6 Oth	ne (Enneite	1
	27. Manner of Deeth	28a. Date of Injury		-				how injury occur		/
on ding in time	1 Natural 5 Pending	(Month, Day		ijury M	28c. Injun	(? Yes 2 □ No				
DIVISION (Hospital or Attending P 44 hours after deeth. Funeral Director: After tely filled in by the funer lical Certification:	2 Accident 3 Suicide 4 Homicide	OB Class of Injur	y - At home, far (Specify)				28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number.
Hospi 24 hou Funer stely fill		nysicien: To the best of miner: On the basis of e and manner state	xamination and							
within To the comple	29b. Signature and title of certifier		-1	W 2	29c. License	number		29d. Date signed	d (Month, E	Day, Year)
F3F8	D. O .1	1 III	1 (5.11.	000	31826			107-	96	
	Michard		, culuc		010E	,		10-1-	17	
	30. Name and address of person who									
	RICHARD L.LINT			OSLE	R DR	IVE TOW	SON, MD	.21204		
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar	s Signature	6	7	1.				



Please Type or Print in Biack Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Philip Randolph Pendleton DOTOBER 08, 1999 01:40PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar If Under 24 Hrs 8. Data of Birth (Month, Dey, Year) July 27 1927 Birthpiaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Months 1⊠M 2□ F 72 212-24-8429 Maryland Usuat Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. tnslda City Limits N/A 1 X Yas 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zin Code 10c. Citizan of What Country? 6307 Blackburn Court 21212 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Datas: 1 Nevar Married 2 Married 1945-1 ☐ Yas 2 No Specify: Specify: þ 3 Widowed 4 Divorced White 1952 Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Safety Officer State Government 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfred Patterson Pendleton, Sr. Mary Grace Roberts 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Jenkins Pendleton (Wife) 6307 Blackburn Court Baltimore, Maryland 21212 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Mathod of Disposition cemetery, cremetory or other pleca) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 10-11-99 Greenmount Crematory Baltimore, Maryland 21. Signature of Funaral Service Licensee 22. Nama and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Teven 1. outh Baltimore, Maryland 21212 6500 York Road 23a. Part1. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Batween Onset and Death Immediata Causa (Final disaasa or condition resulting in death) CEREBROVASCULAR ACCIDENT 1 DAY Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequenca of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical axaminar? 26. Placa of Death (Check only one) Hospitat: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, factory, offica building, atc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. or Attending Physicien: death. 24 hours effer deat Funerel Director: Hospital within 2

Funeral

Director

- MOHe

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

with the Marylend

death .

i filed within 72 hours after if Hygiene. other than "natural", or ite

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked othh eny Injury or other traumatic event and.

Physician

/Medical

Examiner

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physician s the buriel

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To the

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29a. Certifier

(Check only

29b. Signatura and titla of certifier

this

After

Baitimore, Maryland 21215-0020

State Registrar

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) DRIVE ER Sent Registrar's Snature

FRANCIS KHOO M.D., 7601 OSL

DHMH 16 Rev 6/95

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

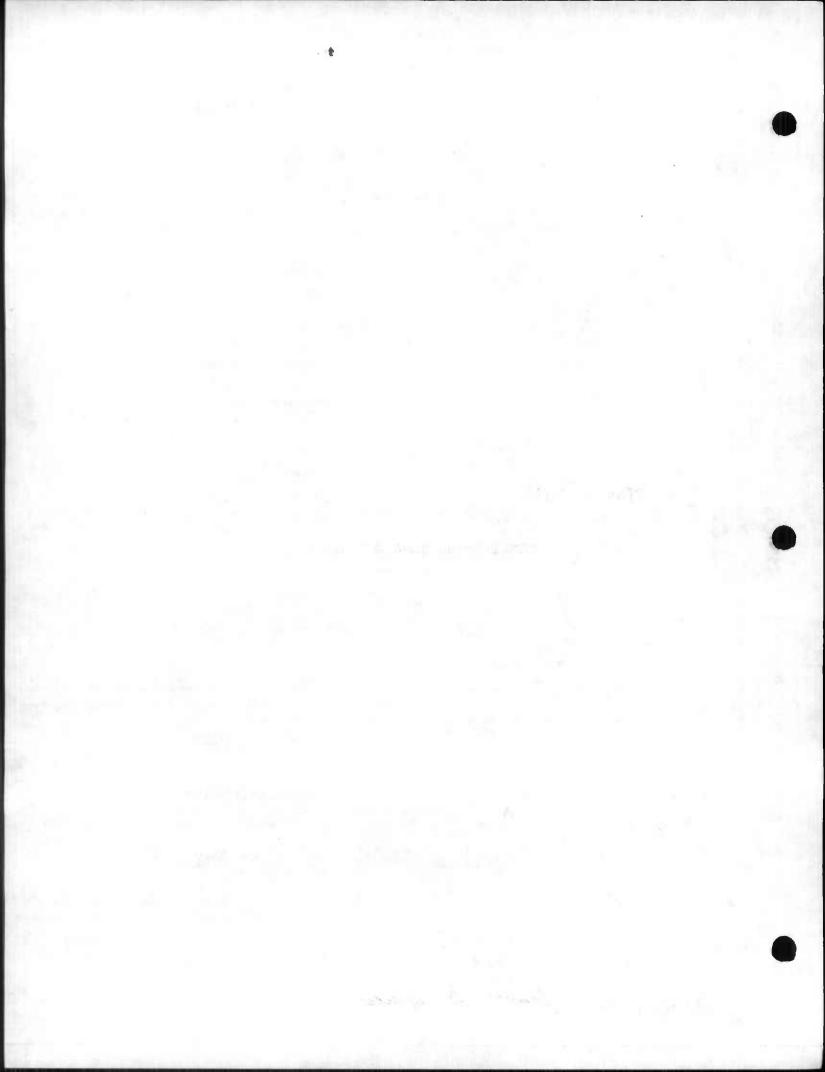
D30263

29c. License number

TOWSON, MD. 21204

29d. Data signed (Month, Day, Year)

10-08-99



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryla

and / Department of Health and Me	ental Hygiene	90	21
Certificate of Death	Reg. No.	3)	0 1

	41 4 40 A - 41					Death			Reg. No.		
1. Decedent's Nama (First, Mana)		SCALO	FF					2. Data of De Month	Day	Year 1999	3. Tima of Death 7:28 P.M
4a Facility Nama (If not institu					4	b. City, To	wn, or Lo	cation of Deat		ty of Death	7.5.20
Church Hospit	tal					Bal	timo	re		N/A	
5. Social Security Number	6. Sex	7. Aga (In yrs	. last birthday)	If Under Months	1 Yaar Days	If Undar		8. Date of Bir (Month, Di	th Vend	9. Birtho	place (Stata or Foraign
56482-0553	A 1 M 2MF	4:	Yrs.	Months	Days	nours	IVIII1.		9,1957	Cour	A.
Usual Rasidence of Decedent	t								1, 1-1		
10a. Stata 10b. Cou	1	10c. C	ity, Town or Lo	cation						1	Od. Inside City Limits
MD, 10e. Street and Number	NA		BALT	imor	3S						12 Yas 2 □ No
10e. Street and Number				10f. Zip	Code				10g. Citizen o	What Cour	ntry?
135 5. 6	CUPLEY &	ST.			2	1224	1			110	a
13.5 S. Constitution of the state of the sta	12, Was De	cedent Evar in U	U,S. 13. \	Was Deced	dent of H	ispanic On	gin? (Spe	ecify Yas or No Rican, atc.))- 14. Ri	ice - Amaric	
1 Never Married 2 N	Armed f Married 1 ☐ Yas	orces?					, Puarto	Rican, atc.)	В	ack, White,	etc.
3 □ Widowed 4 Divor	If Vas G	iva		1 ☐ Yas 2	2 No	Specify:			Spec	by: WW	ITE
15. Dece	ident's Education		16a. Deced	dent's Usua	al Occup	ation			16b. Kind of		
(Specify only high	ghest grade completed		(Giva	kind of wor DO NOT us	rk dona d se retired	during most)	of worki	ng			
Elementary/Secondary (0-1	College	(1-4or 5+)		Lomen					OWN	Home	6
				JIIICA	1111		r's Name	(First, Middle	. Maidan Suma		
m 1	PASCALOFF					_			iscHEA		
			405 44.71	a Address	10						Codel
19a. Informant's Name/Ralati		250		-					er, City or Tow	-	
CARL J. PASEA	COTY CFN					HWEST	JA.	G. F.	ARGO N		
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	ion 3 DBernoval fron		Place of Dispo cematary, cren	natory or o	na or ther plac	e)	11	Date Date	20c. Location	- City or To	own, Steta
4 Donation 5 Other			ETRO (CREM	ATOR	Y	1	112/99	BALTI	MCKE	W.D.
21. Signature of Funaral Serv	viga Licanspe		22	Nama an	d Adden	a of Facility				1	44.00
1		- 49		. Ivallia all	d Addrag	S OF FACILITY	(- 41 C F	INVERA	of defe	mc-
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231 Party Entar the disease	e, or complications that List only one cause on	caused tha dea		322	- S	HIGH	57	BA	40. T	nd 2	1202 Approximate Interval Batween Onsat and Death
	e, or complications that List only one cause on	Caused tha dea		322	- S	HIGH	57	BA	40. T	nd 2	Approximate Interval Batween
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State Registrar

31. Data filed (Month, Day, Year) OCT 12 1999

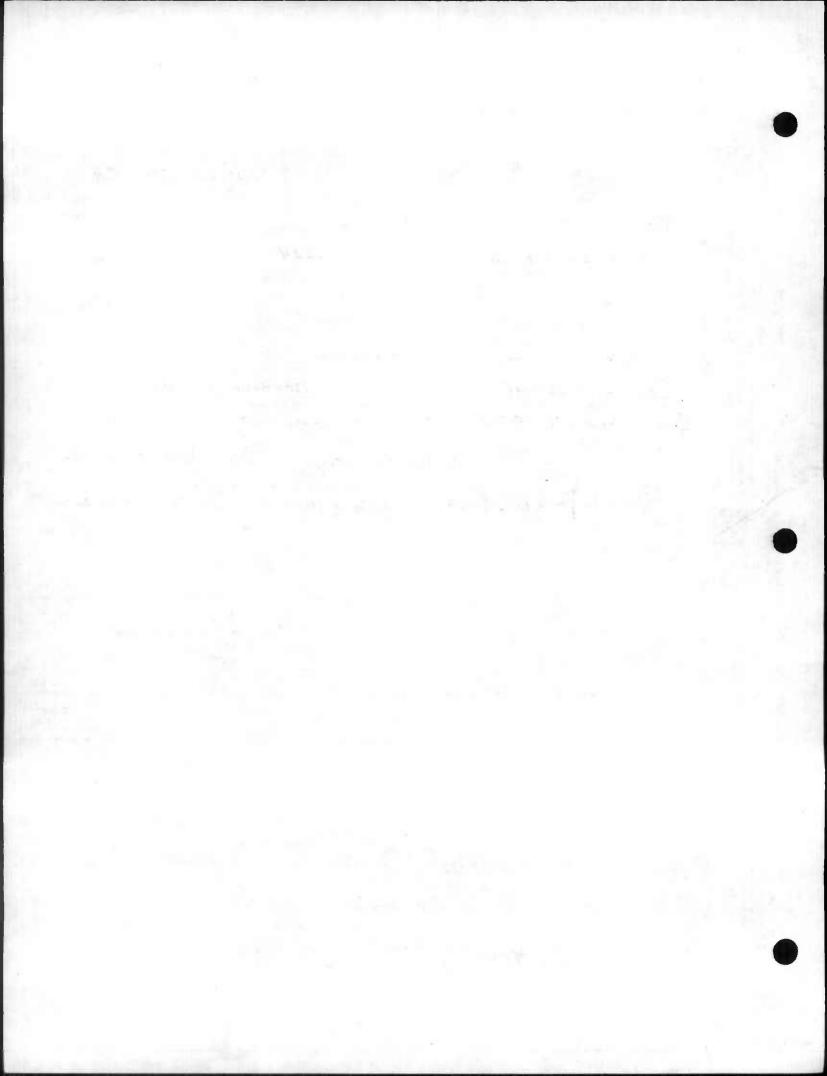
30. Name and addrass of person who completed cause of death (liker 23a) (Type, Print)

· abdul 1/2 game

Abdul K. Garuba, M.D. 32. Registrar's Signature

100 N. Broadway, Baltimore, Maryland 21231

October 10, 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** RITZEL Oct. 1999 20:10 DOMENICA /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical System N/A Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 24,1929 Birthplace (State or Foreign Country) **Funeral** 10 M 200 F Months Days Hours Min. 217-24-1597 70 Yrs. Director Maryland Usual Residence of Deceden r 28a-f show indiffed at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be Berns 23a 3905 Darleigh Road 21236 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. than "natural", or llan the Medical Examiner. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0020 Specify: White p 3 THVidowed 4 □ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Etementary/Secondary (0-12) College (1-4or 5+) Televisison 12th Credit Manager permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: if Nem 27 is marked other any Injury or other the 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be John L.Butta Virginia Cherigo 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 3905 Darleigh Road Perry Hall Maryland 21236 Debroah Ritzel/Daughter Baltimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/99 Rosedale, Maryland Gardens of Faith 21. Signature of Funeral Service Ligen 22. Name and Address of Facility
David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, or contributions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only or e cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Sepsis 2 weeks disease or condition resulting in death) Examiner Due to (or as a consequence of): Aortic Stenosis Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). 68760 Physician/Medical Due to (or as a consequence of): 88 Box 950 23b. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4∑ Unknown Hypoxic brain injury ģ 24b. Were sutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy parformed? Completed peen Renal failure 1 ☐ Yes 2 ☐No 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Hospital or Attanding PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After t 1 Natural
2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier

Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Dey, Year)

30. Nama and andress of parson who completed cause of death (Item 23a) (Type, Print)

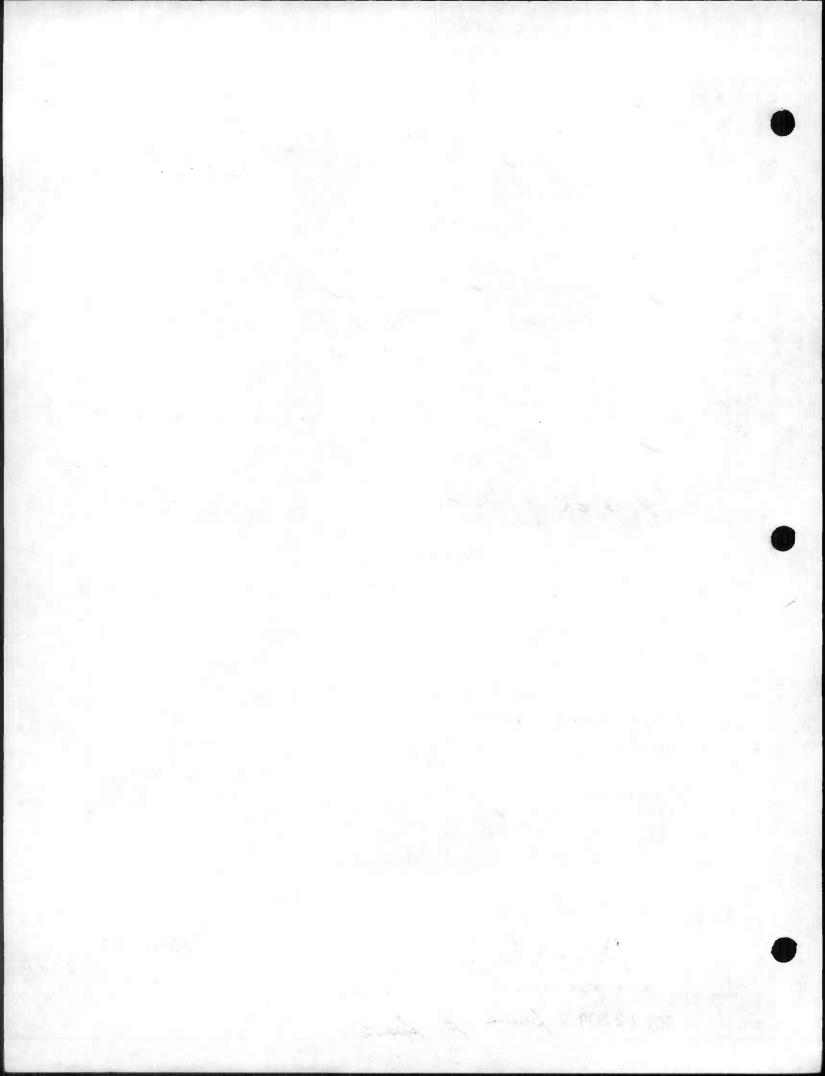
HINDELHEIM

32. Registrar's Signature Sports

ORIGINAL

12432

Univ. of Maryland 22 S. Greene St. Balto, Md



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#23aptII,28a perPhyG776 10/12/99 EW Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day Sept. 27, MARGARET ESTELLE ROUDABUSH 1999 5:07 p.m. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Year 8. Data of Birth 9. Birthplace (State or Foreign Month, Day, Year) Jan. 1, 1915 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours 1 M 2 F Days Months 234-01-8017 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Fallston Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Millwood Drive 21047 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 (Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Secretary Bank 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Lewis Ashby Bowers Margaret Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 219 Tyler Avenue, St. Michael's, MD 21663 Bertram Lewis Roudabush (Son) 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 19/30/99 Baltimore. Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 210 21. Signature of Funeral Service Licensee Welles 21014 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

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Baltimore, Maryland 21215-0020

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physician and the burial-transit

VIII Records, P.O. Box 68760 after deet Director: Hospital 24 hours a Funerel C

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nysic	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying o	ause given in Part f.	23b. Did tobacco use co	ontribute to the cause of death?
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pleted by	Hip frack	MARA	tpar. Ac		24a. Was an autopsy performed?	24b. Wera autopsy findings available prior to completion of cause of death?
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9	25. Was case referred to medical			26. Place of De	eath (Check only ona)	
0	examiner? 1 Yas 2 No	Hospital: 1 ☐ Inpatient 20	ER/Outpatient 3 DC	OA Other: 4 Nursing	Home 5 ☐ Rasidence 8 ☐ Ott	ner (Specify)
ation:	27. Manner of Death 1 2Naturat 5 Pending 2 Accident Investigatio		28b. Time of tnjury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred
PTITIE	3 Suicide 6 Could not b	28e. Place of Injury - At h building, atc. (Speci	nome, tarm, street, tactory	y, office	28t. Location (Street and Numi City or Town, State)	ber or Rural Route Number,

To the I within 2

ALGRED SPARKS MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

West MACPHAIL RA RELAIR 21014 615

State Registrar

Medical

29a. Certifier

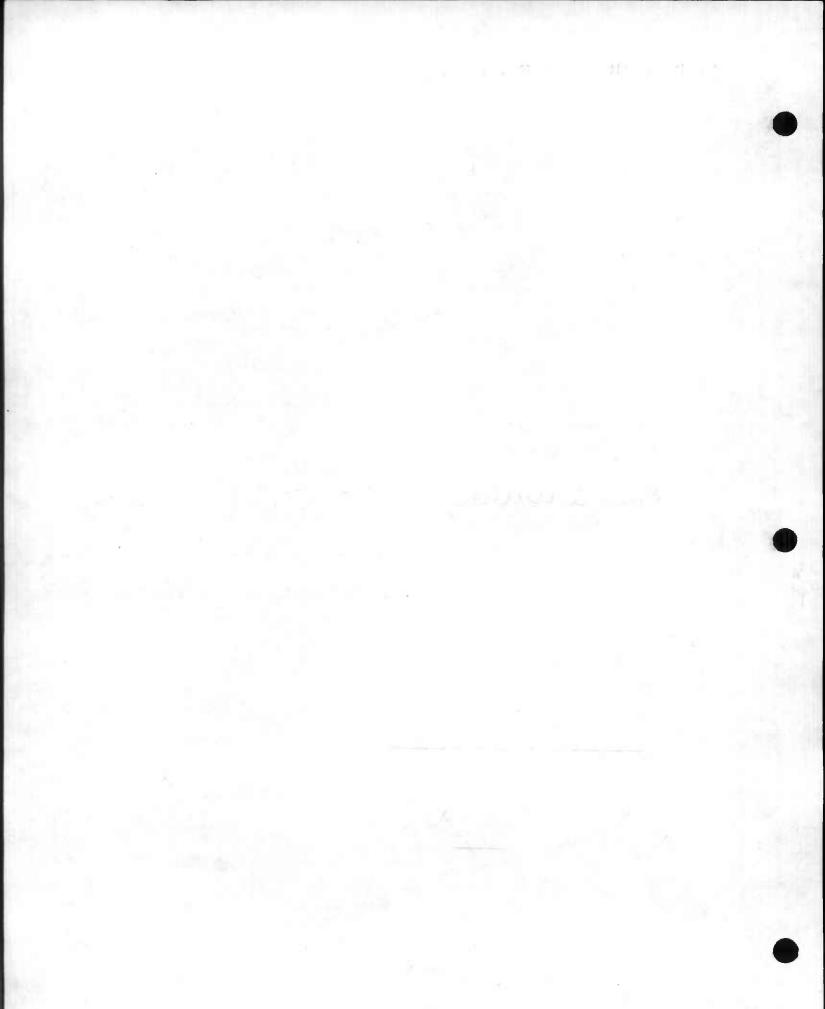
(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner at ated.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day RODWELL **Physician** NHOE 10:10 pm 1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath Examiner CENTER HOSPITAL BALTIMORE HARBOR If Under 1 Year if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplaca (Stata or Foreign Country)
North Carolina 6 Sex 7. Aga (In vrs. last birthday) **Funeral** 1 M 2□F Hours Days 238-01-9020 Yrs. Director 87 12-24-1911 Usual Rasidance of Dacedant the Maryland 10b. County 10c. City. Town or Location 10a. Stata 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yas 2 No AA CO Glen Burnie Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 909 USA Andrews Rd 21061 permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If fem 27 is merked other than "natural", or items 23s any injury or other traumatic event. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: white þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Md. Dry Dock Welder 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Emily Q. Cain Dr. John W Rodwell 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19a. informent's Name/Relationship (Type, Print) 909 Andrews Rd Glen Burnie Md 21061 John H. Rodwell Jr Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata oot 9, 1999 Baltimore 4 ☐ Donation 5 ☐ Othar (Spacify) metro Cremodory 22. Nama and Addrass of Facility 21. Signature of Funeral Service Lic Fink Funeral Home Pa or pemplications that causad the death. Do not enter the mode of dying, such as dardiac or respiratory arrest,
Approximate and one causa on each line.

Approximate the mode of dying, such as dardiac or respiratory arrest,
Approximate the mode of dying, such as dardiac or respiratory arrest,

Approximate the mode of dying, such as dardiac or respiratory arrest, Approximata intarval Between Onsat and Death **Physician** Immediate Ceuse (Finel disease or condition rasulting in death) /Medicai RESPIRATORY DAY FAILURE Examiner Dua to (or as a consequance of): Examiner 7 DAYS SEPSIS physician and the burial-transit Sequantially list conditions, if any, laading to immadiate ceusa. Enter Undarlying Ceusa (Diseesa or injury that inflieted events rasulting in daath) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) as usa Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? D.O. FAILURE CHRONIC RENAL signed b λq 24b. Wara autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy Completed LARGE RETROPERITONEAL MASS MALIGNANCY OF PROBABLE RIGHT ADRENAL 25. Was cesa rafarred to madicel axaminar? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 26. Plece of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Data of Injury (Month, Dey Yaar) 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: 5 Pending invastigation 1 Waturai after death. Director: Aft 1 Yas 2 No 2 Accidant 6 Could not be determined 28a. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 3 Sulcida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homleide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steled.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. 29e. Certifiar Medical To the Hosp within 24 hou To the Fune complately fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number M Pauch, PGY-1 INTERN OCTOBER 6 P 1347

Registrar

State

DHMH 16 Rsv 6/95

DCT 12 1999

31. Data filed (Month, Day, Year)



1 Yes 2 No 3 Probably 4 Unknown

30. Nama and address of person who completed causa of daeth (Item 23a) (Type, Print)

MARINA S. FARAM, 3001 S MANOUER STREET, BALTIMORE, MD

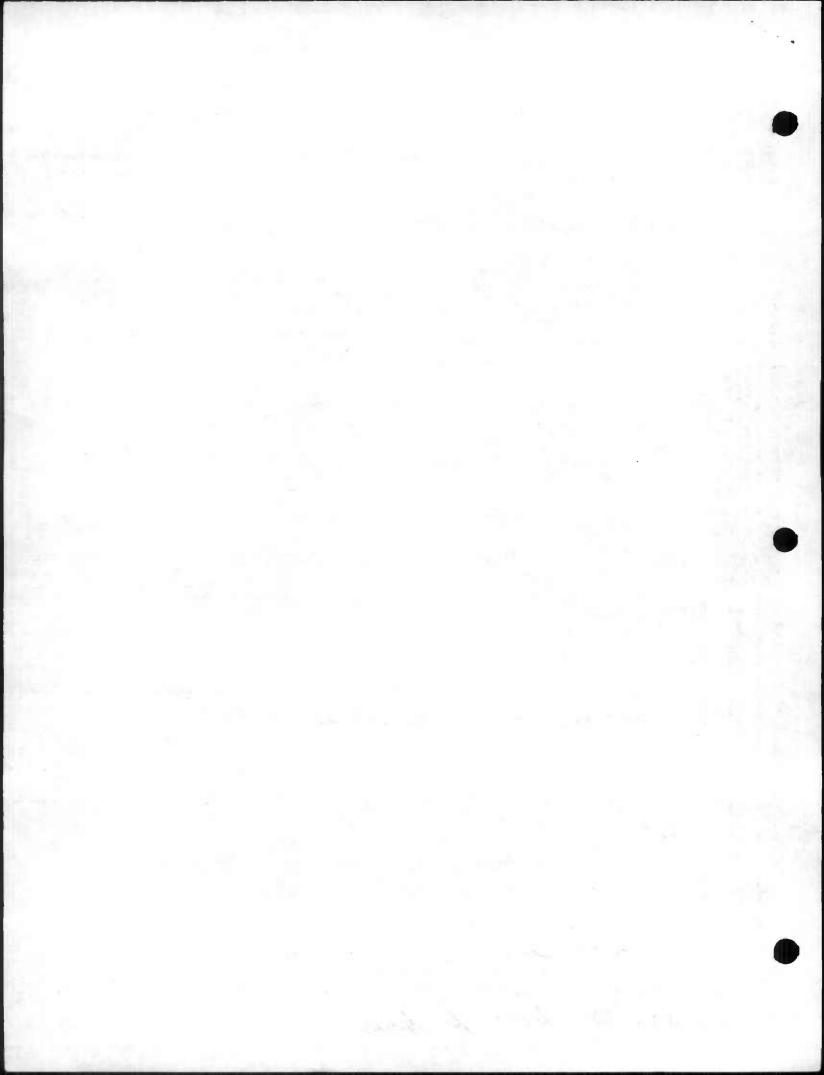
32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HOAM KEED. CHARIE 2CF 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deal Examiner BoltsHORE NGLSON AUG 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 45 2/3 60 1385 mary / pro Director FEB. 11, 1954 Usual Residence of Decedent 10a. State ahow 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or herne 23a or 28a-f ahov the Medical Examiner must be notified at NA BALLINOR 1 No Mary Iso 10e. Street and Number Director 10f. Zip Code 10g. Citizen of What Country? 533/ MELSON USA 2/215 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Merital Status permit. Pages 1 end 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Itam 27 Ia marked other than "natural", or the any Injury or other traumatic event, the Medical Exercitors 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: Black p 3 Widowed 4 Divorced Year or Detes: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Baltiner Orides Elemantery/Secondary, (0-12) College (1-4or 5+) MaintENAnce 12th grade Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) REED, SR. BERNALD Mary 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 2///7 620 ACADEMY AUG Owings Mills, Mary Imo Adam C. REED, JR 20b. Place of Disposition (Name of cemetary, crematory or other place) 20e. Method of Disposition

12 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State PikesvillE, Harylow Cemeter RIDGE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
52 VO Res DRUID CHA THIM- HAMRIE F. H. 21. Signature of Funeral Service Licensee 23e. Perty. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or haart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final Metastetic lung concer 4 martins disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner ician and buriel-transit or Attending Physician: The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting In death) Last Due to (or as a consequence of): physician the buriel Box 68760, by Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Chronic alcohol abuse Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No certificata funarai director. 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of tnjury (Month, Day Year) 27. Mannes of Death 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after deeth. To the Funeral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicida Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completely (Check only one) 29b. Signature and little of certifie 29c. License number 29d, Deta signed (Month, Day, Year) D4037 10/7/99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Havny W. Kaplan, no ao Pzinteus Mill Rd. Svite 126 ownes Mills, ND 21177
31. Date filed (Month, Day, Year) 32. Registrar's Signatura State 1 2 1999 Registrar Sports



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** RICK 4:00 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAKEWOOD If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 6. Sax 9. Birtholace (Stata or Foreign **Funeral** Months 1 🗆 M 213-94-018 Usual Rasidenca of Decede Yrs. SUBMUDA Director 10a. Slata 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at 1 es 2 No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6 1401 LAILEUX20 items 23s RMUA Funeral 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: b 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Falher's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be TAYENDER 70 19a. Informani's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 of Department of Health at Important: If Item 27 is any Injury or other traughts. Thomns WILETE ROSEANNE 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Malhod of Disposition 20c. Location - City or Town, State 1 Imerial 2 Cramation 3 Ramoval from State 4 ☐ Donalion 5 ☐ Othar (Specify) 21. Signal pra of Full eral Service Licenses 22. Nama and Address of Facility HOWEZL 118 21207 560011 23a. Part1. Enlar tha diseasa, or complications that caused tha death. Do not enlar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediala Causa (Final disease or condition rasulting in death) **Examiner** Physician/Medical Examiner Dextension sician and burial-transit Sequantially list conditions, if any, leading to immadiata cause. Enlar Underlying Cause (Disease or injury that initiated events rasulting in daalh) Last Due to (or as a consequence of): physician s the buna P.O. Box 68760 Dua to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 Ho 3 Probably 4 Unknown signed b Records. PV 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 No 1 Tyes 2 100 Division of Vital or Attending Physician: Be 25. Was casa refarred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No edical Certification: To 1 Inpalient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dala of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending invastigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) completely filled in by 4 D Homicide 24 hours a Hospital 1 Certifying Physician: To Iha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 16 Rev 6/95

Registrar

within 2 To the \$

29b. Signature and title of certifier

1. Data filed (Month

1 2 1999

no complated causa of death (Item 23a) (Type, Print)

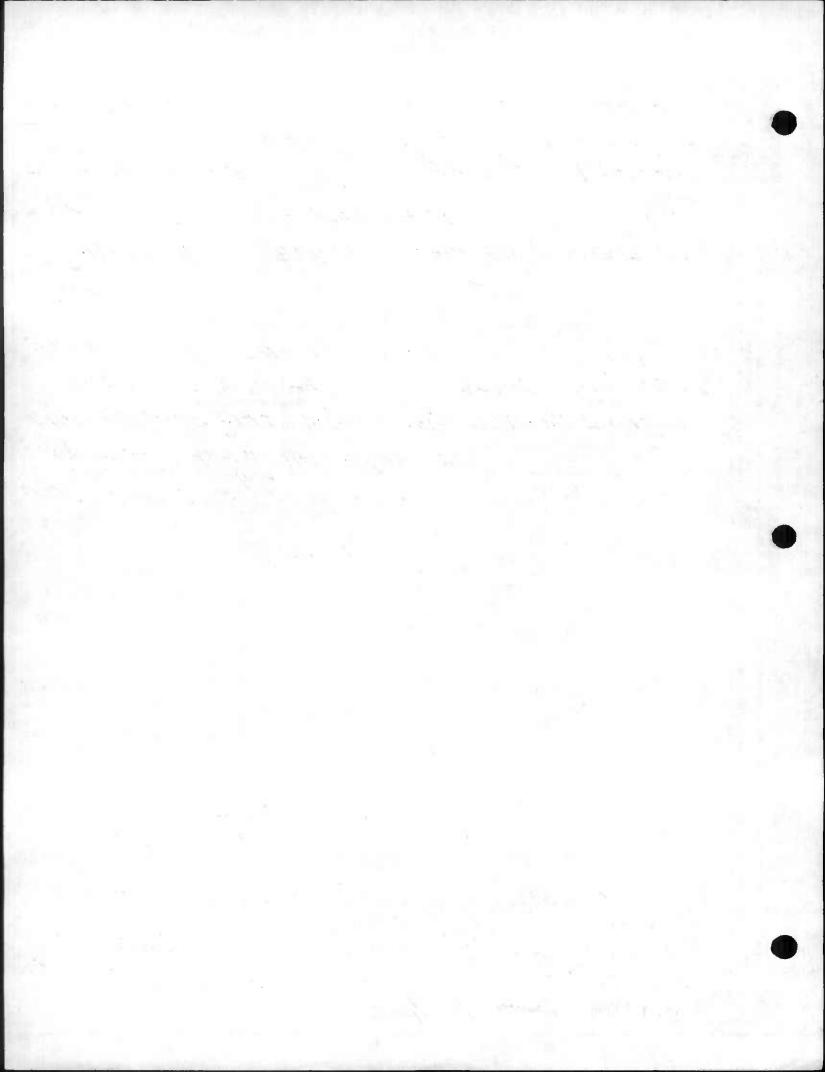
32. Registrar's Signatura

29c. License number

29d. Date signed (Month, Day, Year)

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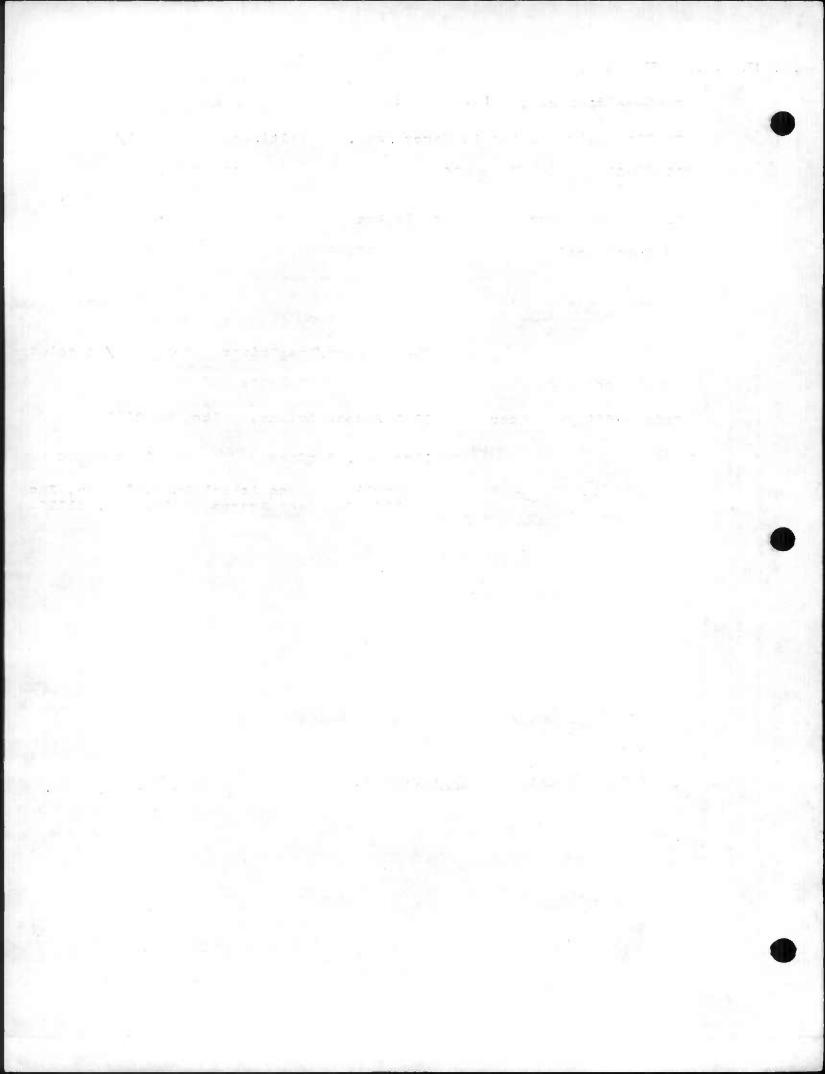
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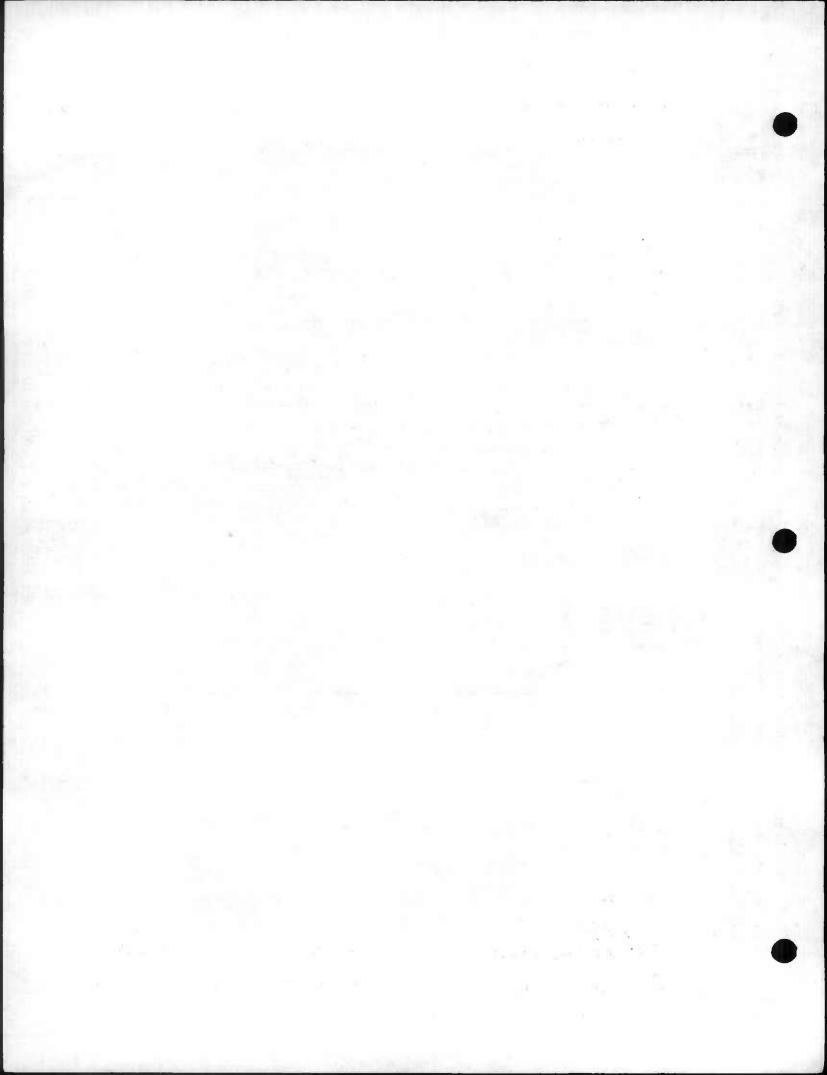
State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #1 PER MD G776 10/12/99 AH Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death EPTEMBER 29,1999 Day **Physician** 135 Icylean R. Roberson ICYLEAN R. ROBERSON /Medical 4e Facility Neme (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice At Mercy Hosp. Baltimore If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country)
 N C **Funeral** Days Months 1□M 20 F Director 237-62-3188 76 12 06 1922 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 288-1 Beaufort Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 23a or 99 Corey Road 27889 USA Funeral or items 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Stetus Bleck, White, etc. hours efter 1 Yes 2 No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: p Year or Detes: 3. Widowed 4 □ Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within and Mentel Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Shop Keeper/Bus Driver Own Shop/School Sys permit. Pages 1 and 2 should be file.
Department of Heelith and Mentel Hy, important: If Nem Z7 Is merked ofthe any Injury or other transmented of the permitted 7. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Frank Roberson Roberta Hodges 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3203 Romona Avenue, Balto, Md 21213 Iris Ruffin/Daughter 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, cremetory or other place) Burial 2 Cremation 3 Removel from Stete
4 Donation 5 Other (Specify) 10/4 Pamlico Mem. Gardens Washington, NC 21. Signature of Funeral Service Montage 22. Name and Address of Facility Sterling Ashton Schwab Funeral hOme, Inc 23e. Perf. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21228 Balto, Md. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Box 68760 Physician/Medical Due to (or as e consequence of): for use es Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown à 1 Yes 2 No Records, by ed bi 24b. Were eutopsy findings eveilable prior to Completed 24a. Was en eutopsy completion of cause of death? page 2 The 1□ Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital 26. Place of Deeth (Check only one)STELLA MARIS AT MERCY Hospital or Attanding Physician:
 Abours after death.
 Funeral Director: After this certification of the funeral director. Be 25. Was case referred to medical exeminer? Hospitel: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Neturel Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 C Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in | Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a, Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 29,1999 DU. 1 M 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) BAHIMORE MDZIZOZ RISEBERG DAVID 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State OCT 12 1999 Registrar



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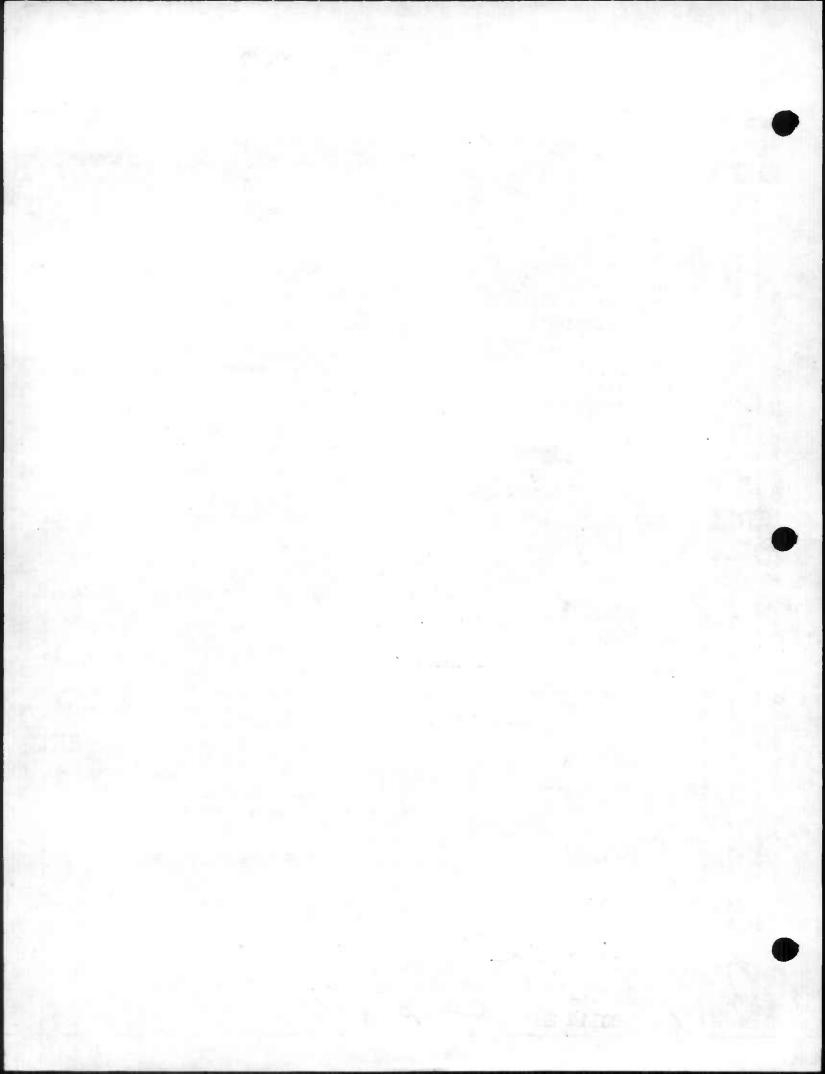
			State of Maryland / De	epartment of Health a Certificate of Death	and Mental Hy	rgiene 9	3 1748
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	/Medical Examiner Funeral Director	4a Facility Name (If not institution, give THE JOHNS HOPKIN 5. Social Security Number 6. S	street and number) S HOSPITAL	BALTI day) If Under 1 Year If Under 1 Months Days Hours	wn, or Location of Deat	th 4c. County	
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5-0020 72 hours after deeth with the Mandend	al', or items 23s or 28s-f show Exercion: must be notified at by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Z∑ No If Yes, Give Year or Dates:	13. Wes Decedent of Hispanic Origif Yes, specify Cuban, Maxican ↓ Yes 2 □ No Specify:	gin? (Specify Yes or No , Puarto Rican, etc.)		e - American Indien, k, White, etc.
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more,	4 4 4	19a. Informant's Name/Relationship (I CARLOS RIVERI 20a. Method of Disposition 18 Burial 2 Cremetion 3 Communication 5 Content (Specify	COUSIN) P. 20b. Place of Competery,	hisposition (Neme of cremetory or other pleca)	Dete PAL 16-15-99	PUERT 20c. Location - COROZ	TO RICO 007 83 City or Town, State ZAL, RUERTO RICO
Balti	Depa Impo any li ansa	21. Signature di Funeral Seguice ticon		J8548 W. 4 =	ULTONA	VE BAL	TO. MD. 21217
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E	xaminer	disease or condition resulting in death)	Due to (or as a co				ONE WEEK
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Box 687	tby the attending physicie etached for use as the bur Physician/Medical	that initiated events resulting in death) Last	Due to (or es a co	nsequence of):			
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he Hospit	in 24 hour he Funer pietely fill edical	29a. Certifier 150. Certifying Phyone) 2 Medical Exam	raician: To the best of my knowledge, of iner: On the basis of examination and/and manner stated.	leath occurred et the time, date end or investigetion, in my opinion, deet	d place, end due to the th occurred et the time,	cause(s) end me date and place, a	nner es stated. and due to the cause(s)
Tot	With the state of	29b. Signatural Marketiner	, PGY-1	29c. License number RES-000			10, 1999
9	+	30. Name and address of person who o	completed cause of death (Item 23a) (T	/pe, Print) NORTH WOLFE STRI	EET, BALTIN	MORE, MD	21287
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	5. Sparks			



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State of Maryland / Department of Health and Mental Hygiene

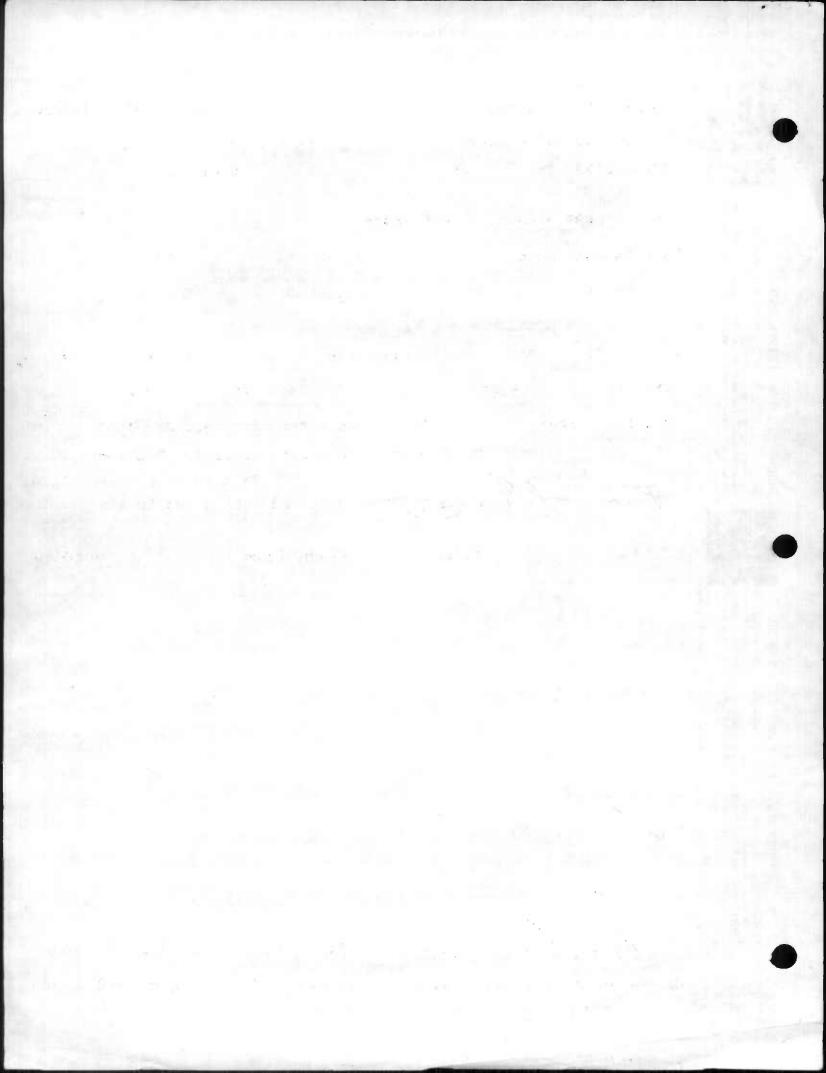
				,	Certificate	of Death		Reg. No.	5 51145
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	Physician	DANIEL				STEWART	OCTOBE	-	99 6:06a.m.
Y	/Medical Examiner	4a Facility Name (If not institution, g	ive street and number)			4b. City, Town, or			
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	Funeral		Sex 7. Age	(In yrs. last birt	hday) If Under 1 Y	ear If Under 24 Hrs	8. Date of Bir	th	9. Birthplace (State or Foreign Country)
п	Director	214-64-5522	12XM 2□ F	46	Yrs. Months Di	lys Hours Min	Sep 24		ID
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	nor death v r Hems 23s Siner.must Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	Bleck	- American Indian, c, White, etc.
20	ural, or ha at Examina of by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☒	No Specify:		Specify:	
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p	STOR A	17. Father's Name (First, Middle, Las	1)	· · · · · · · · · · · · · · · · · · ·		18. Mother's Na	me (First, Middle	, Maiden Sumame	э)
Maryland	Mental and a street of antice and a street of a street	Daniel Webster	Stewart, Jr			Elveter	McClou	ad	
ary	EBEE.	19a. informant's Name/Reletionship	(Type, Print)	19b.	Mailing Address (SI	reet and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)
	and 2 ealth a n 27 is ner trav	Mrs. Rosemary St	ewart-Wife	27	724 E. Jef	ferson Str	eet, Bal	ltimore,	MD 21205
re	- I I I	20a. Method of Disposition		20b. Ptece of	Disposition (Name o	1	Date		City or Town, State
Ĕ	Pages net: # lb my or o	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			us Memoria		Oct 13	Baltimo	re, MD
Baltimore,	ermit. Appartm mports my inju	21. Signature of Funeral Service Lice	ensee // 2	9	22. Name and A	dress of Fecility			
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P.0	requires that the de- seen signed by the a hould be detached i	3,417	ATUEDOCCI	EDOCTO			10	Yes 2 No	3 Probably 4 Unknown
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	and and	29b. Signature and title of earlings	and manner stat	led.	29c Li	cense number		29d Date signed	(Month, Day, Year)
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	1	30. Name and address of person who				D = 1 + 1	W- 1	1 01007	
		PIERRE R. THEO] 31. Date filed (Month, Day, Year)		UU Nort		Baltimore	,marylan	a 2128/	
	State Registrar		N	VAA.	y. Spa	KS			
		OCT 12	1999		//				



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				Ce	ertifica	te of	Death		Reg. No.	3 1 1 3 0
		1. Decedent's Name (First, Middle, Las	t)					2. Dete of Dec		3. Tima of Deeth
п	Physician /Medical	Daniel &	Segar					OCTOBE	271	999 1150am
1	Examiner	4a Facility Name (If not institution, give					4b. City, Town, or	Location of Death	4c. County	
		Harbor Hospita	l Center				Baltim			IA
	Funeral Director	5. Social Security Number 229-40-3592 6. Sec. 11	7. Age (in yrs.	last birthdey Yrs.	Months	er 1 Year Deys	If Under 24 Hrs Hours Min.		h y, Year))-34	Birthpiece (Stete or Foreign Country) VA
	p ,	Usuei Residence of Decedent 10e. Stete 10b. County	100 0	ty, Town or I	agation					10d Isoldo Othe Limits
	Maryla a-f ahov	MD Anne A		Hanc						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28	10e. Street and Number			10f. Z	ip Code			10g. Citizen of W	/het Country?
	23a ch wi	7612 Harmans R	oad		2	1076	5		USA	
020	of within 72 hours after death with the Maryland plena. Than "natural", or flems 23s or 28s-f show the Modeal Examiner must be nuithed at completed by Funeral Director.	11. Maritel Status 1 Never Merrled	12. Wes Decedent Ever in L Armed Forces? 1 ☐ Yes X T\No If Yes, Give Yeer or Dates:	J,S. 13	. Was Dec if Yes, sp		lispenic Origin? (Sen, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race Blec Specify	e - American Indian, sk, White, atc.
5-0	72 ho	15. Decedant's Ed (Specify only highest grad		16e. Dec	edent's Us	uaf Occup	ation	nkina	16b. Kind of Bu	usiness/Industry
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Maryland	sho end	19a, Informant's Name/Ralationship (7	ype, Print)	19b. Me	iling Addra	ss (Street	end Number or R	ural Route Numbe	er, City or Town,	Stata, Zip Code) 21076
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Baltimore,	Se to T	20e. Method of Disposition 1	Removal from State G	Cernietery, Cr	ALLIA LOLA OL	Other Die	100/	10-12-9		timore, MD
Balt	permit. Pag Department Important: If any injury o	21. Signature of Funeral Service Licans	19 -							ryland 21202
r		23a. Part1. Enter the disease, or companies shock, or heart failure. List only of	effications that caused the doc	th. Daugora	oler the me	. Mar	ch FH ng, such as cardia	C or respiretory e	North	Avenue Approximete Intervel Between
)	Physician /Medical Examiner	Immediata Cause (Finei disease or condition rasulting in death)	a. Pulm	O Y CL	equenca o		bulis	n		Onsat and Death
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m	death cerding of for use	Part II. Other eignificant conditions co	ontributing to deeth but not re-	suiting In the	underlying	cause ni	ven in Pert i	23b. Did	tobacco une cor	ntributa to the causa of death?
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Records,	The law requires the complete has been signed paged 2 should be completed by								en eutopsy ormed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
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of	this raidi	1 Yes 2 No 27. Manner of Deeth 1 Natural 5 Pending	28e. Deta of Injury (Month, Day Year)	ER/Outpati 28b. Time Injury	of	28c. Inju Wo		Home 5 Rasi 28d. Describe	dance 6 Oth-	
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	6 4 € 4	Mayor () in m	m						
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	State	31. Dete filed (Month, Day, Year)	32. Registrar's Sign	ature	y. ~	Spor	25			1000

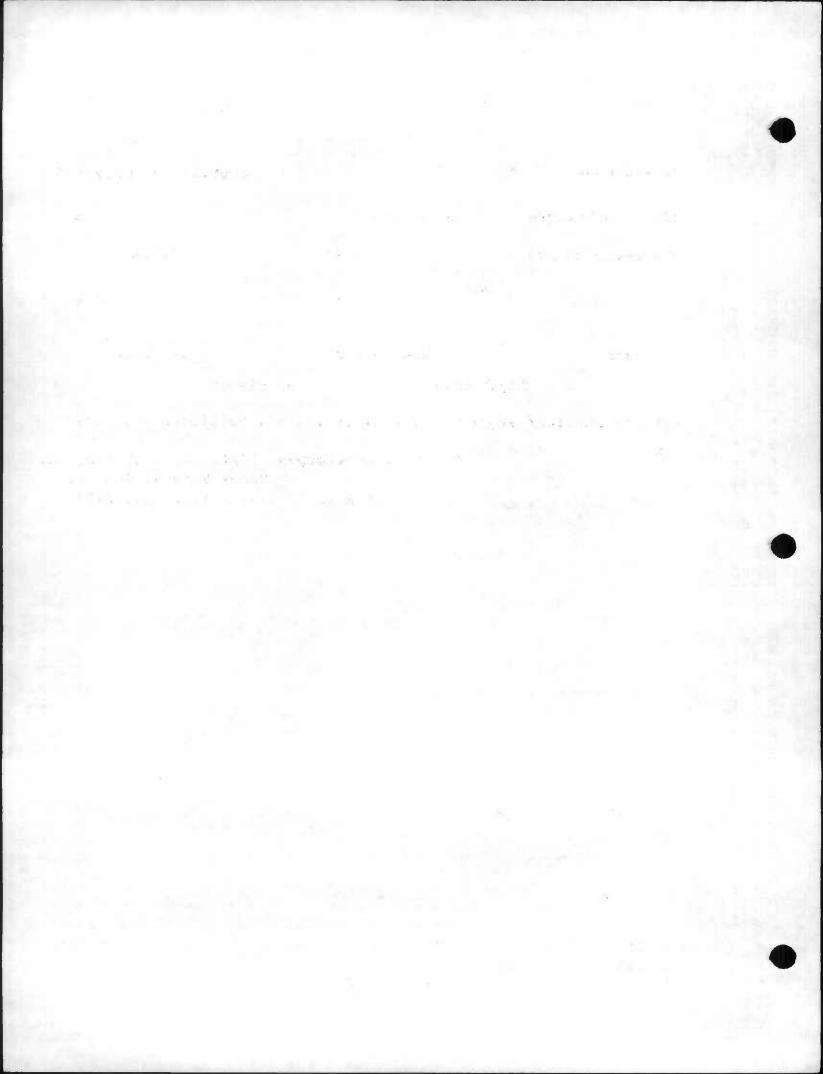
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State of Maryland / Department of Health and Mental Hygiene 000001

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ral tor	5. Social Securit	3-0038	х 7. Age	(In yrs. lest bi	Yrs. If Unde Months		If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Di 9/26	rth ay, Year) /1924	9. Birthplace (State or Forei Country) Maryland
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Oirec	10e. Street and	Number			10f. Zij	p Code			10g. Citizen of Wh	nat Country?
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by Funeral Director		larried 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2010 If Yes, Give Year or Detes:		13. Wes Dece		penic Origin? (S , Mexicen, Puert Specify:	pecity Yes or No o Rican, etc.)		- American Indian, , White, etc. White
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_		s Name/Reletionship (T)			b. Mailing Addres	s (Street a	nd Number or Ru	ıral Route Numb	per, City or Town, S	State, Zip Code)
		ah Schline	e/daught				ew Rd.			., 21225
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	21. Signature of	Funeral Service Licens	*	1.						Home P.A.
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n	shock, or	of the disease, or compl heart failure. List only o	ne cause on each lin	e.	not entire no	de or dying	, such as cardiac	or respiratory t	arest,	Approximete Intervel Between Onset and Death
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ı.	disease or cond resulting in dea	th)	a	Due to (or as a	consequence of))		
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edical Certification: To Be Completed by Physician/Medical	25. Was case re examiner? 1 Yes 2 27. Manner of D 1 Statural 2 Accider 3 Suicide 4 Homicide 29e. Certifier (Check only one)	gnificant conditions c	d	t not resulting t not resulting t not resulting 28b. ry - At home, f. (Specify) f my knowledge examination ended.	Body consequence of) in the underlying. utpatient 3 D Time of Injury M arm, street, factor e, death occurred and/or investigation	OA Othe 28c. Injury Work 1 Yry, office	26. Place of Det 7. 4 Nursing F at 7. es 2 No 9, dete end plece inion, death occu- number 2441614	23b. Did 1	Yes 20 No s en eutopsy ormed? Yes 20 No one) idenca 6 □Other how Injury occurre (Street and Number Index, State) c ceuse(s) and man, date and place, ar	3 Probably 4 Unknot 24b. Were autopsy finding evallable prior to completion of cause of death? 1 Yes 2 No I (Specify) Id If or Rural Route Number, Index to the cause(s) (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tims of Death Month Dss Yası 45 1999 Ctober 6 Sanders Alvin 4e Escility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Desth Baltimore H Undar 24 Hrs. 8. De NA Stella Maris Mercy ff Under 1 Yaar 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foraign Country) Months Days 10XM 2□ F Yrs. 54 218-42-7566 Usual Rasidence of Dacedant 10b. County 10c. Cify, Town or Location 10d. Inside City Limits 1 Yes 2 No Pikesville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. 4 Sturgis Ct. 12. Was Decedant Evar in U,S. Armed Forcas? 1XXxes 2 □ No if Yas, Giva Yaar or Datas: 14. Race - American Indisn, Black, White, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 11. Marital Status 1 Never Married 2 Ms mied 1 Yas XNo Specify Specify 3 Widowed 4 Divorced Black 16a. Decedent's UsusI Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Al Pharma USPD Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Work Leader 12th grade 17. Fether's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Marlene Pickens George W. Sanders 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Sturgis Ct, Pikesville, Md 21208 Margaret Sanders-Wife 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Ststa 1 ☐ Surial 2 ☐ Cramation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 10/12/99 Owings Mills, Md 21. Signsture of Fynars! Sarvice Licenses March F/H West 4300 Wabash Ave, Baltimore Md 21215 6 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximats Interval Batween Onsat and Daath Immedista Causa (Fins) Moonship disease or condition rasulting in death) Dua to (or as a consequence of) Sequentially list conditions, if sny, leading to immediata causa. Entar Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was sn autopsy performed? complation of causa of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) No Sput 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tims of 28d. Dascribe how injury occurred

Physician /Medical Examiner that the death certificate be executed and

Physician

/Medical

Examiner

10a. Stata

Funeral

Director

or 28s-f show

Berns 23a

natural, or

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permit. Pages 1 and 2 should be fit.
Department of Health and Mantal Hy, important; if Nem 27 is marked offine any Injury or other

altimore. Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

filled within

Director

Funeral

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Completed

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Examiner physician the attending p 2 been signed to should be detr page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification physician by the funeral director; I Be Medical Certification: To

certificate

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Physician/Medicai Completed

29a. Certifiar

25. Was cesa rafarred to medical examinar? 1 Yas 2 No 27. Manner of Desth

1 Natural
2 Accident

6 Could not be datarmined 3 Suicide 4 Homloide

28a. Data of Injury (Month, Day Year) 5 Pending invastigation

28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify)

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Buttwore

281. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicisn: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of ceptifier

MD

29c. Licansa number 040854 29d. Data signed (Month, Day, Year) OF 6/00

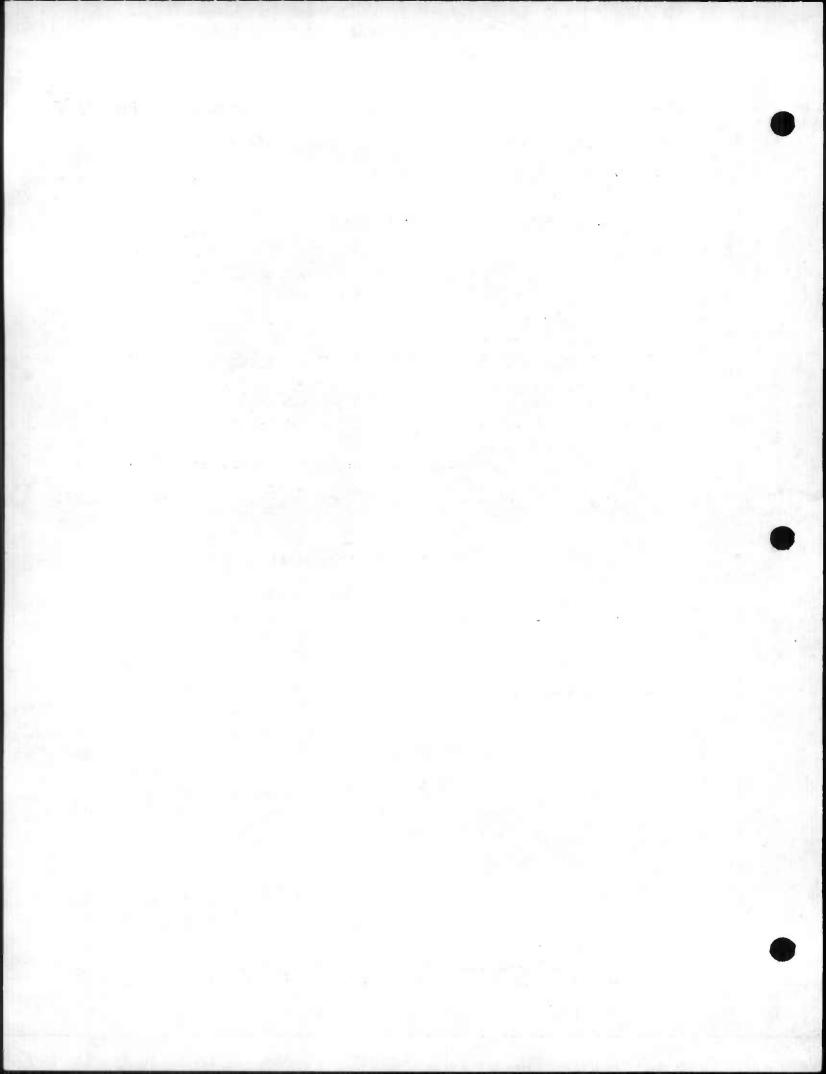
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30. Name and sddress of person who completed cause of death (Itam 23a) (Type, Print) 31. Data filed (Month, Day, Year)

OCT 12

32. Registrar's Signature Preva

State Registrar

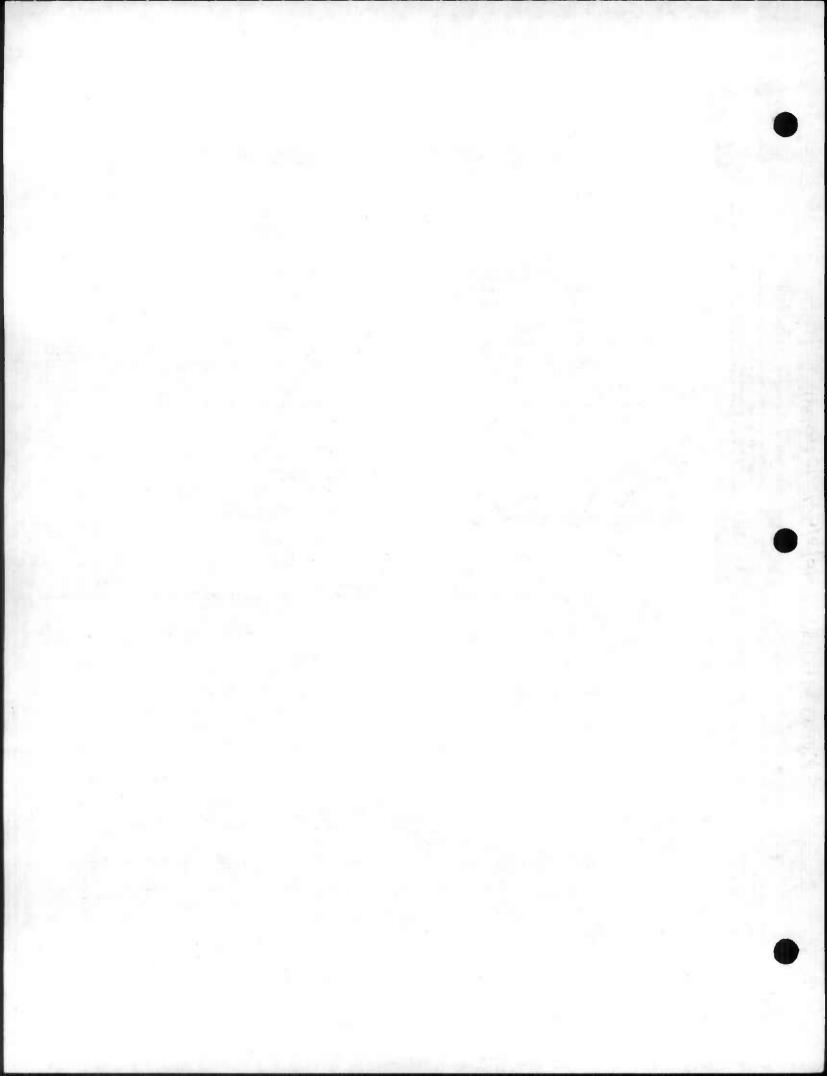


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/Medical	WILL	-LIAM	4.	STE	1 2N S						OCT	6 1	999	12-79
Examiner	4a Facility N			street and num					b. City, Tow	m, or Lo	cation of Death	4c. Count	y of Death	
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uneral	5. Social Se	curity Number	6. Ser	x 7	7. Age (In yrs.	last birthday)		r 1 Year	If Under 2	4 Hrs.	8. Date of Birth			
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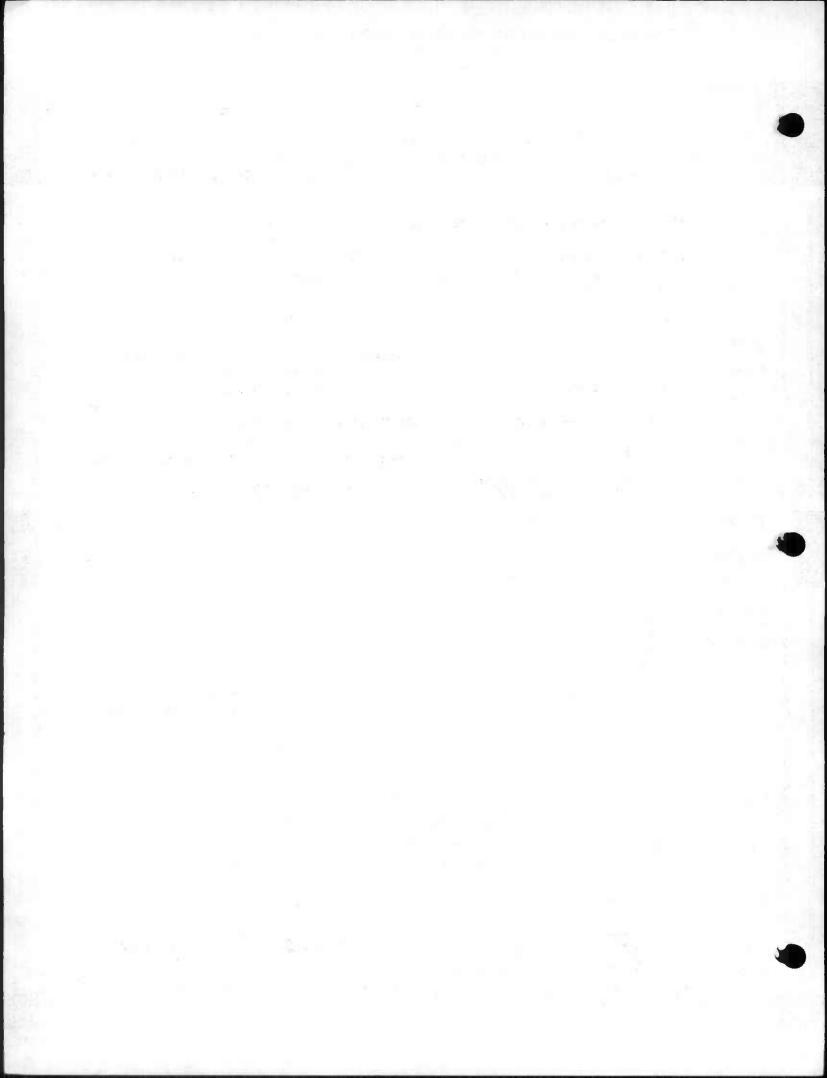
DHMH 16 Rev 6/95

Stevens, William 10/6/99 12:45pm



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	u Mentai riy	Reg. No.	31754				
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Vera Maxine Squires	2. Deta of D Month	Dey Yee	3. Time of Deeth				
	Examir		4e. Fecility Nama (If not institution, give street end number) Crofton Convelescent Center Crof	or Location of Dee	th 4c. County of De					
	Funeral Director		305-14-6444 X X X Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	Min. (Month, D	9. 8 ey, <i>Year</i>) 10,1918 Inc	sirthpiece (Steta or Foreign Country) liana				
	yland		Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location			10d. Insida City Limits				
	Ba-f s	ector	MD Anne Arundel Hanover			1 Yas 2 No				
	Sa or	Dir	10e. Street and Number 10f. Zip Coda 1915 Portobago Lane 21076		10g. Citizen of Whet (Country?				
120	72 hours efter deeth with the Meryland natural', or thema 23a or 28a-f show dical Examinet must be notified at	by Funeral Director		? (Specify Yes or Nuerto Rican, etc.)	o- 14. Race - An Bleck, Wh	narican Indien, nite, etc. White				
Baitimore, Maryland 21215-0020	5	Completed i	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work dona during most of life. DO NOT use retired)	a during most of working		es/Industry				
ZD	filed with Hygiene. other than			Name (First, Middle	Own Home a, Meiden Sumeme)					
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Mar	d 2 sho th end I 7 is me traum	ľ	19e. Informent's Neme/Reletionship (Type, Print) Kimmy Huff - Daughter 19b. Meiling Address (Street and Number of 1915 Portobago Lane							
more,	permit. Pages 1 end 2 Department of Health of Important: If Item 27 is any injury or other tra		20e. Method of Disposition 1 Buriel 2© Cremetion 3 Remove from Stata 4 Donetion 5 Other (Specify) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Metro Crematory	Dete 10/9	20c. Location - City of Baltimore	or Town, Steta				
Balti	Departition Departments any Injury In		21. Signature of Fyneral Service Ugensee 22. Name end Address of Facility Hardesty Funeral 12 Ridgely Ave.							
2	Physician /Medical Examiner		23a. Pen1. Enter tha disease, or complications that caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter tha mode of dying, such as caused the death. Do not enter that mode of dying and death. Do not enter the mode of dying and disc	olac or raspiratory i	arrest,	Approximata Interval Between Onset and Death				
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	requires that the deeth certific been signed by the attending p should be deteched for use es	by Phys	Chronic obstructure pulmonory chiace,			Probably 4 Unknow				
บั	2 ss &	Completed t	Seizure duording		s an eutopsy 24b omed?	b. Were eutopsy findings eveilable prior to completion of cause of deeth?				
	The harden			10	Yes 2 No	1 ☐ Yes 2 ☑ No				
	To the Hospital or Attending Physician: The is within 24 hours effer deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To Be	exeminer? 1 Yes 2 No Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Sexure 1 DOA 27. Menner of Deeth 1 Neturei 5 Pending (Month, Dey Year) 2 Accident Pending (Month, Dey Year) 28b. Time of the third	28d. Describe	one) idence 6 □Other (Sp how Injury occurred	pecify)				
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2	vithin ;	M	29b. Signeture and title of destriction MD 29c. License number D 38958	-	29d. Dete signed (Mo	nth, Dey, Year)				
(Sta	te	30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) Doublet 5: Sight 1413 Annapolis 31. Deta filed (Month Day, Year) 32. Registrar's Signature	Rd #	106 Oc	Jenton, mi				
	Registr	ar	Wil 12 1999 June 9. Spark							



ROXANNE SCHUNKE State of Maryland / Department of Health and Mental Hygiene Certificate of Death

If Under 1 Year

Months

Days

	(1)	- 1	2		1
		9	- 1	day.	4
,	6	1	1	U	U

Physician
/Medical
Examiner

Roxanne M. Schuncke 4a Facility Name (If not institution, giva street and number)

Month OCTOBER 9,1999 4b. City, Town, or Location of Death

3. Time of Death 7:26P.M.

7444 MANCHESTER ROAD 5. Social Security Number 1□ M 2□√F

1. Decedent's Nama (First, Middla, Last)

DUNDALK If Under 24 Hrs.

Hours

4c. County of Death

BALTIMORE

Funeral Director

must be notified at

or items 23a

filed within 72 hours after Hyglene. Hyglene.

permit. Pegas 1 and 2 should be filed with Department of Health and Mental Hygiens Important: if Nem 27 is marked other than pince.

Physician /Medical

Examiner

physician and the buriel-transit

signed by the e

Box 68760,

P.O.

Records,

Division of Vital

f or Attending Physician: "
efter death.
Director: After this certifica

within 24 hours efter To the Funerel Direcompletely filled in b

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

Baitimore, Maryland 21215-0020

Director

à

Completed

Be

218-82-9775 **Usual Residence of Decedent** 10a. Stata 10b. County Md. Balto.

10c. City. Town or Location Dundalk

Yrs.

7. Age (In yrs. last birthday)

38

Aug. 31, 1961 Balto. Md

2. Date of Death

8. Data of Birth (Month, Day, Year)

10d. Inside City Limits

1 Yes 2 No

9. Birthplace (Stata or Foreign Country)

10e Street and Number

10f. Zip Code

10g. Citizen of What Country?

U.S.A.

7444 Manchester

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Datas:

 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2 No Specify:

21222

14. Race - American Indian Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

Rd.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Md. General Hosp

17. Father's Nama (First, Middle, Last)

Elementary/Secondary (0-12)

Martin Schuncke 18. Mothar's Nama (First, Middle, Maidan Surnama) Myrna Erat

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 7811 Kentley Rd., Balto., Md. 21222

Martin Schuncke/Father 20a. Method of Disposition

20b. Place of Disposition (Nama of cemetery, crematory or other place)

20c. Location - City or Town, Stata

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Chesapeake Crematory 10-1-2-99 Beltsville, Md.

22. Nama and Addrass of Facility

Nurse

21. Signature of Funeral Service Licenses

Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Rd., Balto./, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Immediata Cause (Final

Dueto

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consult

Due to (or as a consequence of)

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1 Yas 2 □ No 26. Place of Death (Check only ona)

1 Yas 2□ No

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month Day Year) 5 Pending investigation 10

28e.

28b. Time of 28c. Injury at Work? : 14 PM

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No

28d. Dascribe how injury occurred Subject

Stabbed and Cut 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lauenester Home

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

O.C.M.E.

OCTOBER 10, 1999

29d. Date signed (Month, Day, Year)

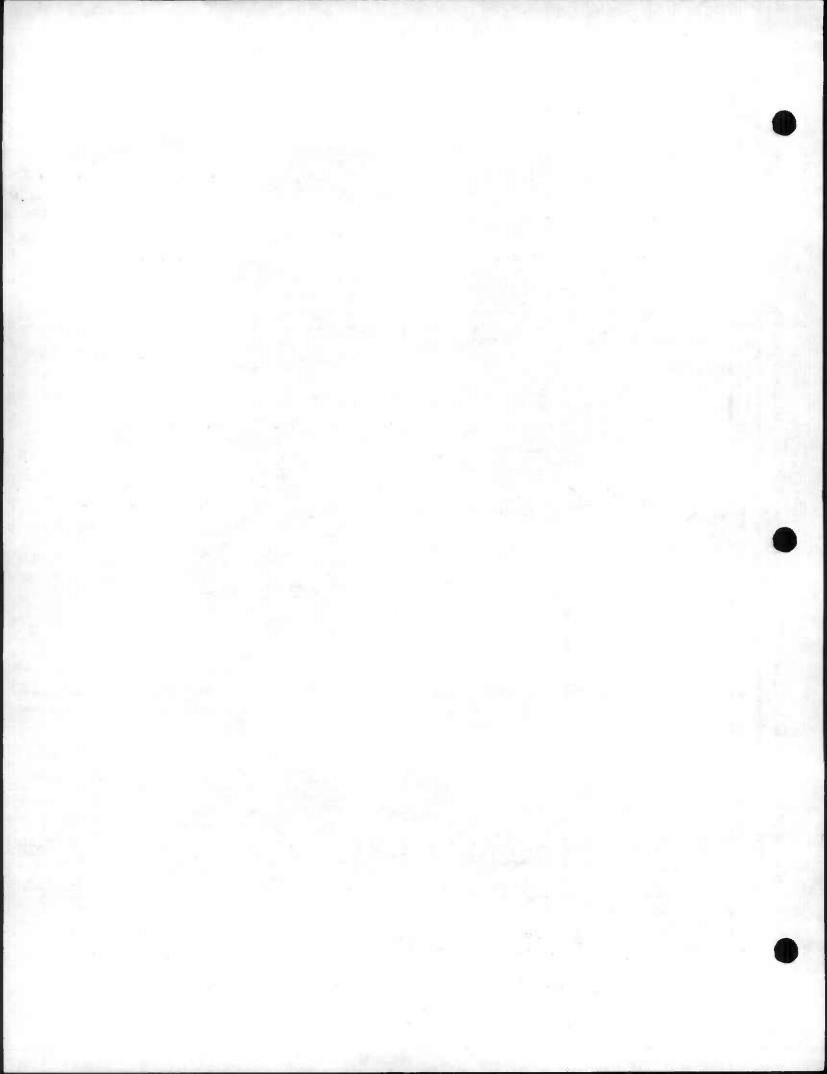
completed cause of death (Item 23a) (Type, Print)

Day. 32. Registrar's Signature

6 Could not be

111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #1 PER MD G776 10/12/99 AH 2. Dete of Deeth 3 Time of Deeth 1. Decedent's Neme (First, Middle, Last) Alfred Woodburn Smith 4b. City, Town, or Location of Death 4c. County of Dea **Physician** /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Baltimore City Maryland General Hospital N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country)
 I L 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 1□M 2□F 357-40-5699 53 Yrs. Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e. Stete 10b. County 1 □ Yes 2 □ No Baltimore Md N/A Directo 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be IISA Franklin Street 21201 501 W. Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HIID Clerk 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Rozella Johnson 2 Theodore Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Department of Health an important: If them 27 is 914 Perryville Rd. Danville, Il 61832 Patricia Gibson/Sister 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Danville, Il Spring Hill Cemetery 10/4 4 ☐ Donetion 5 ☐ Other (Speciful 21. Signeture of Funerel Service Lie 22. Name end Address oi Fecility Sterling Ashton Schwab Funeral Home, W 736 Edmondson Avenue, Balto, Md. e, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. 23a. Part / Enter the disease shook, or heert feilure. Approximete tntervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or es a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es a consequenca of): Division of Vital Records. P.O. Box 68760, Due to (or es e consequenca of) resulting In deeth) Lest 23b. Did tobacco use contribute to the cause of geath? been signed by the should be datached Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveileble prior to completion of cause oi deeth? 24e. Was en eutopsy Completed has 10 2 irector, page 2 1 Yes 2 No Hospital or Attending Physician: director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA this 27. Manne of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: After 1 Naturel 5 Pending investigation 1 Yes 2 No death. 2 Accident d in by the 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier edical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier MD 30. Neme end ediress of person who completed cause of death (Item 23e) (Type, Print) General Hospital maryhad ELISA. Gil C 31. Dete filed (Month State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Neme (First, Middla, Last) 3. Tima of Death Physician October 10, 1999ar Thelma P. Schlining 1:50am /Medical 4b. City, Town, or Location of Death 4e Facility Nema (If not institution, give street and number) 4c. County of Death **Examiner** Ellicott City 3004 N. Ridge Road Apt 316 Howard If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 216-01-9536 1 □ M 2 🕱 F Director Oct. 6, 1917 Maryland Usual Rasidanca of Decedant 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show Howard Ellicott City 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 parmit. Pages 1 and 2 should be filled within 72 hours effer death w Department of Health and Mentel Hygiene. Important: If Nem 27 is marked other than "natural", or herne 23a any Injury or other traumetic event, the Med 3004 N. Ridge Road Apt 316 21043 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collaga (1-4or 5+) Homemaker Own Home 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Matthew Platt Anna Hines 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) 3200 Pine Bluffs Drive, Ellicott City, MD 21042 Paula Harris (Daughter) 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Di Buriel 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Loudon Park Cemetery 10/13/99 Baltimore, Maryland 22. Nama and Addrass of Facility Witzke Funeral Homes, Inc. 21. Signatura of Funeral Sarvice Licenses 1630 Edmondson Avenue, Catonsville, MD 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final Obstructive Pulmonary Disease disaasa or condition rasulting in daath) Examiner Physician/Medical Examiner attending physicien end for use as the buriel-trensit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, Dua to (or es a consequança of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure by 24b. Were autopsy findings available prior to complation of causa of deeth? 24a. Was an eutopsy performed? Completed Cos Palmmale 1 Yas 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

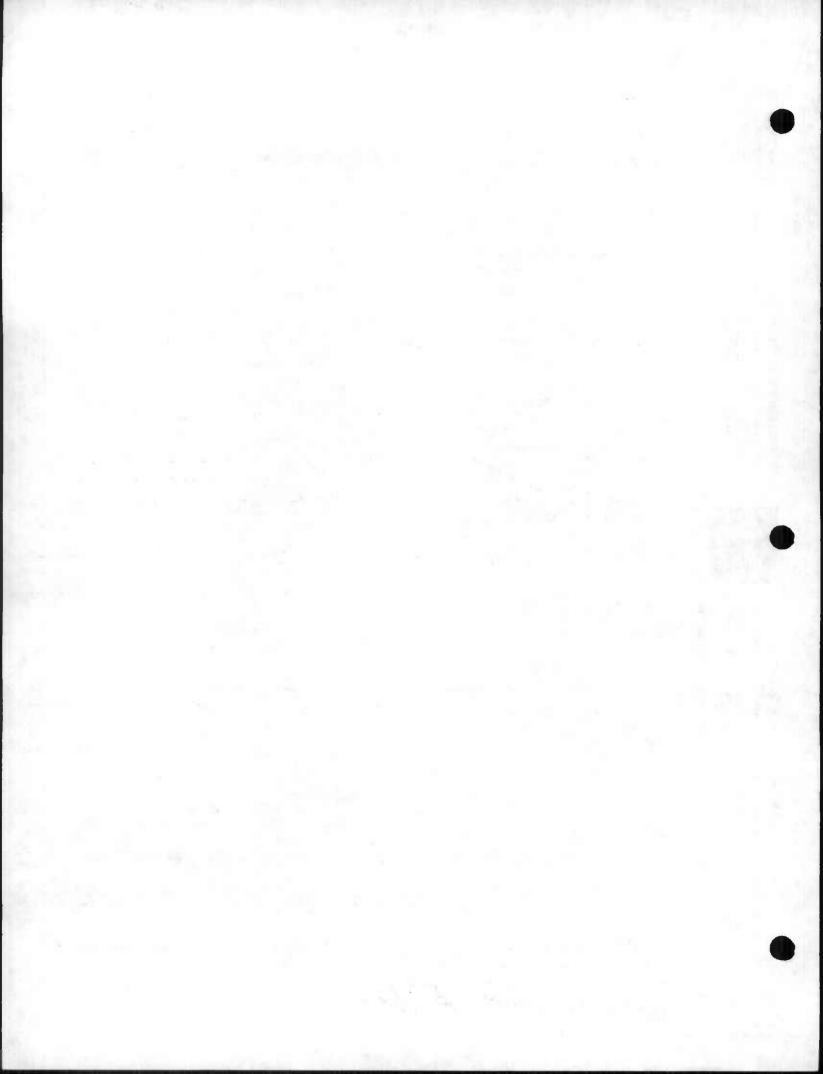
To the Funeral Director: After this certifica completely filled in by the funeral director; I 25. Was casa rafarred to medical axaminer? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 PResidence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Tima of 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and dua to the cause(s) end mannar as stated.

| Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29a. Certifiar (Check only one) 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) frareson, MD D-0053636 October 11, 1999 30. Nema and addrass of person who complated causa of death (Item 23a) (Type, Print) 5 32 Dogiotrar's Signatura Done Ellrott City, MD 3460 Carlson

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 7, Dey 1999 Year **Physician** RAYMOND DANGERFIELD SENTZ 1:00AM /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Parkville Baltimore Oakcrest Village 8810 Walther Blvd If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) April 3, 1921 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Days Min. Hours XXM 2DF Months 077-12-7313 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahow the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore Parkville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 8810 Walther Blvd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? ★CXYes 2 □ No WW I I Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or than eny injury or other traumatic avent, the Medical Exercised biology. Bleck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes XIX No Specify: White Specify: py 3∕ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Executive Aerospace 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Raymond Thomas Sentz Gladys Dangerfield 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnformant's Neme/Reletionship (Type, Print) DTR 3811 Hadley Square East Baltimore, Maryland 21218 Valerie Golueke 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State
Donetion 5 Other (Specify) Greenmount Cemetery 10/11/99 Baltimore, Maryland 4 (Wonetion 22. Neme and Address of Facility Mitchell-Wiedefeld Funeral Hame Inc ature of Funeral Service Licens 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cardiopulmonary 5 mins Examiner Due to (or es a consequence of): Examiner Actery Disease oronary physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Atherosclerotic Box 68760. Vascular y ears Physician/Medical Due to (or es e consequence of) P.O. 23h. Did tobacco use contribute to the cause of death? Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown The law requires that of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 Yes 1 TYes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) edical Certification: To this 27. Menger of Death 28d. Describe how injury occurred 28a. Dete of tnjury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera 28b. Time of 28c. tnjury at Work? Division 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 6 Could not be 3 ☐ Suicide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

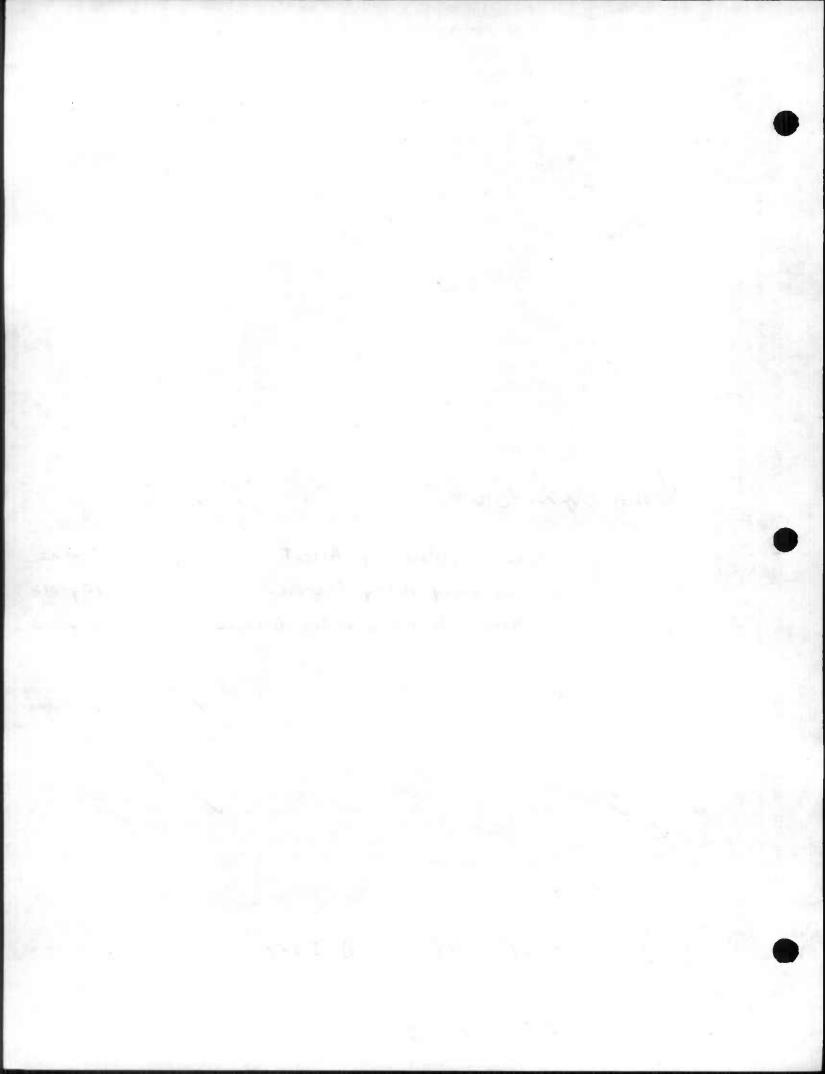
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D25349 October 8, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Peter J Golueke 6565 North Charles Street Towson, Maryland 21204 32. Registrar's Signature 31. Dete filed (Month, Day, Year)

AHIC

DHMH 16 Rev 6/95

State Registrar

ORIGINAL



99-6101-005

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier								_		
	State	of I	Maryland /	Department	of	Health	and	Mental	Hygier	ıe

WILL	IAM
CTEM	א דיירי

99 31759

STEWART						Cei	uncate o	Death		Reg. No.					
		1. Decedent's Nemo	e (First, Middle, L	ast)					2. Date of De Month		Year	3. Time of Death			
Physicia /Medic	_	Willia	m		Stewa	rt			OCTOBE	Dey CR 9.199		7:26P.M.			
Examine	_	4a Facility Name (I		ive street and nu				4b. City, Town, or	Location of Death			7.201.111			
		7444 MANO	CHESTER	ROAD				DUNDALK		BALTI	MORE				
Funeral		5. Social Security N	umber 6.	Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24 Hrs		h		elace (Stele or Foreign			
Director		216-66-	4190	1 2 \$M 2□F		43 Yrs.	Months Day	ys Hours Min	Aug 4		MD	ntry)			
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	0	MD	Balti	more	Di	ndalk						1 ☐ Yes 2 XNo			
	5	10e. Street and Nun		. IIIOLE	DC	illuain	10f. Zip Code	B		10g. Citizen of	What Cour	ato/?			
	<u></u>			המ								N.y,			
	era	2057 Jasmine Rd 11. Medial Status 12. Was Decedent Ever in U.S.				C 42 9	2122		Coorie Vas or No	US	A. ce - Americ	en Indian			
	5	11. Merital Status	ed 2 Married	Armed Fo	orces?	13.	f Yes, specify C	of Hispanic Origin? (Suban, Mexican, Pue	rto Rican, etc.)	Bla	ck, White,				
8 9 P	b	3 Widowed		1 ☐ Yes If Yes, Giv Year or D	VO		1□ Yes 2☑N	lo Specify:		Specia	y: Wh	nite			
within 72 hours after ene. than "naturel", or he he Medical Examine			15. Decedeni's E		-a165.	16e Dece	dent's Usual Occ	cupation		16b. Kind of B					
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Health Hem 27 I	ŀ	20a. Method of Disp	. Stewa	irt /I	ather		I Kava	naugh_Ro	Date	20c. Location		21222			
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pemit. Pac Departmen Important: any Injury once.		21. Signature of Fu	neral Service Lice	90see			Name and Add	tress of Fecility							
Ded Person		1 ant	long C	Conn	Day			lly Fune Sollers				11K			
		23a. Pert1. Enter the shock, or hear	ne disease, or cor nt failure List only	mplications that o	aused the deet	th. Do not ent	er the mode of d	tying, such as cardia	ac or respiratory a	rrest,		Approximate Intervel Between			
Physician			V			1 ,	1	1		0	1.5	Onsel end Death			
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deeth a atter ed for	3	Part II. Other eignifi	cant conditions	contributing to de	eath but not res	ulting in the u	nderlying cause	given in Pert I.	23b. Did	tobacco use co	ontribute to	the cause of death			
	Physician								10	Yes 2 No	3 Pro	bably 4 Unknow			
clan: The law requires th ertificate hes been signed ector, page 2 should be decompleted by										an autopsy		ere autopsy findings			
	lete								perfo	rmed?	co	eilable prior to mpletion of cause death?			
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									108	Yes 2□No	1,5	Yes 2 No			
	m	25. Was case referr examiner?	ed to medical	Hoepitat:			14		eath (Check only o						
la din	9	117 Yes 2 1			·	ER/Outpatier	I 3LI DOA		Home 5 Resi			SCENE			
After t	ertification:	 Manner of Death □ Naturat 	5 Pending		of tnjury	28b. Time of Injury	. V		Succibe	how injury occu	int	by Polic			
Attending or death. ector: Afte by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigetion 6 □ Could not I	he 10	9 199	7:1	THY	☐ Yes 2 ☑ No	Subjec	t stubl	sed a	nd Cut.			
after d Direct d in by		4 Homicide	determined	A ZOU. PECA	of Injury - At hing, etc. (Specif	ome, tarm, str	eet, factory, office	0 1	28f. Location (ber or Rura	Route Number,			
in dia	0			Hom	e;	+444	4 1 la	mehester	rkd;	Dan	da	1K, MG			
the Hospital hin 24 hours a the Funeral I upletaly filled	edicai	29a. Certifier (Check only						time, date and place y opinion, deeth occ							
thin 24 the F mplete	_	one)			ner stated.		-								
0 = 0 5	Σ	29b. Signature and	title of eartifier			1	29c. Lice	ense number		29d. Date sign	ed (Month.	Dav. Year)			

To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completaly filled in by the funer Division

29b. Signatur

O.C.M.E.

OCTOBER 10, 1999

30. Name an of person who completed cause of death (Item 23a) (Type, Print) estaner

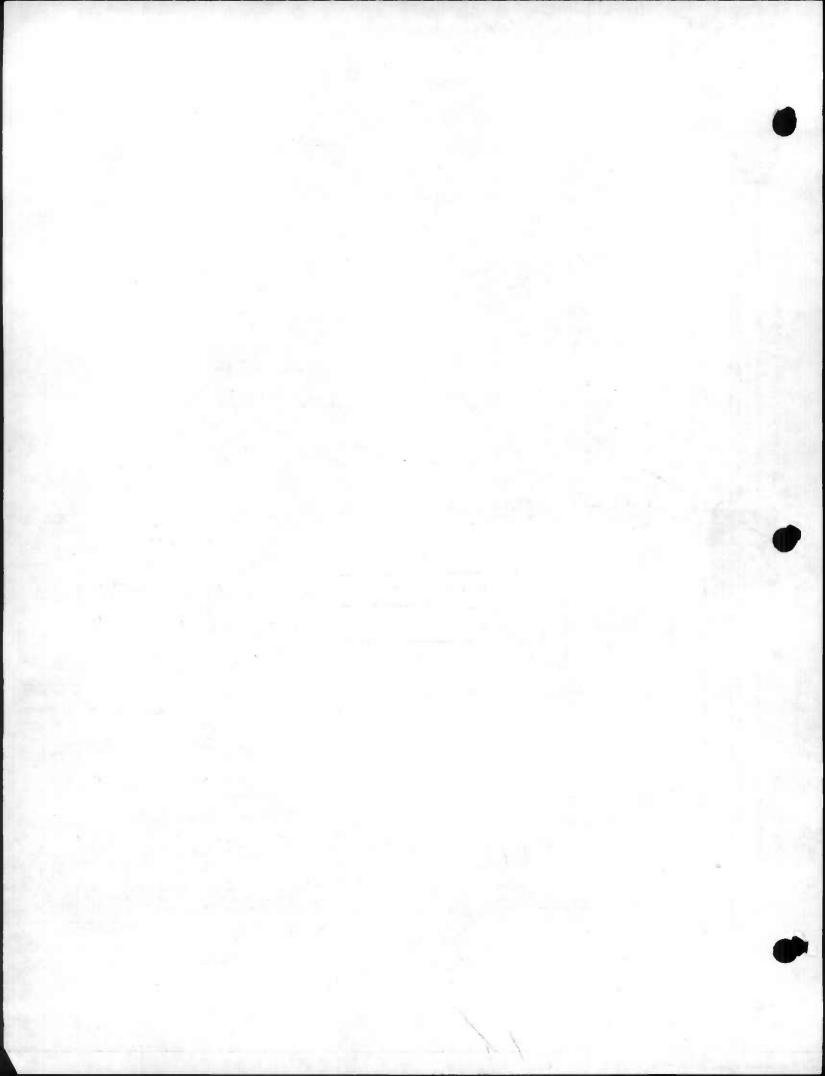
111 Penn Street, Baltimore, Maryland 21201

State Registrar

DSep (Month, Day, Year) 32. Registrar's Signature 2 1999

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Yee Helen Μ. Speranzella 7:30 PM October 8, 1999 4a Facility Name (tf not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Horizon Specialty Center - Canton Baltimore 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Hours 1 ☐ M 2 🖾 F 86 213-28-4097 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6910 Homeway 21222 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Seamstress Clothing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph Prematta Antoinette Zcarcie 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charles Speranzella /son 9269 Bellbeck Rd Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) Oct 12 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 1999 Baltimore, MD 21 Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Pert1. Enter the dise percentage of complications that caused the deaft. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediete Cause (Finel ALRHUMA disease or condition resulting in death) CARDIO VHUILA ALTERIO Ecterite Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Ancionia.

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Directo

Funeral

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Completed

Funeral

Director

23a or 28e-f

thems:

b

I Hygiene.

of Health and Mental H If Nem 27 is marked off For other traumatic even

Department of Important: If any injury or 2058.

Pages 1 and 2 should be filed within 72 hours after

21215-0020

Maryland

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Examiner The law requires that the death certificate be executed attending physician and for usa as the burlai-transit Box 68760. Physician/Medical eigned by of Vital Records. δ been a Completed this certificate has

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. Wera autopsy findings available prior to completion of cause of daeth? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 21 No Other: The Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 C.Neturet 28a. Deta of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 6 Could not be detarmined 3 ☐ Suicide 28a. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical

. Cartifier
(Check onl)
one)

15 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) end menner stated.

29b. Signeture and title of Certified

29c. License number 024276 29d. Dete signed (Month, Day, Year) 10.1199

30. Name and address of purpos who completed cause of death (Item 23a) (Type, Print)

ScALIA 31. Date filed (Month, Day, Year)

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State Registrar

32. Registrer's Signatura

DHMH 16 Rev 6/95

Attanding Physician:

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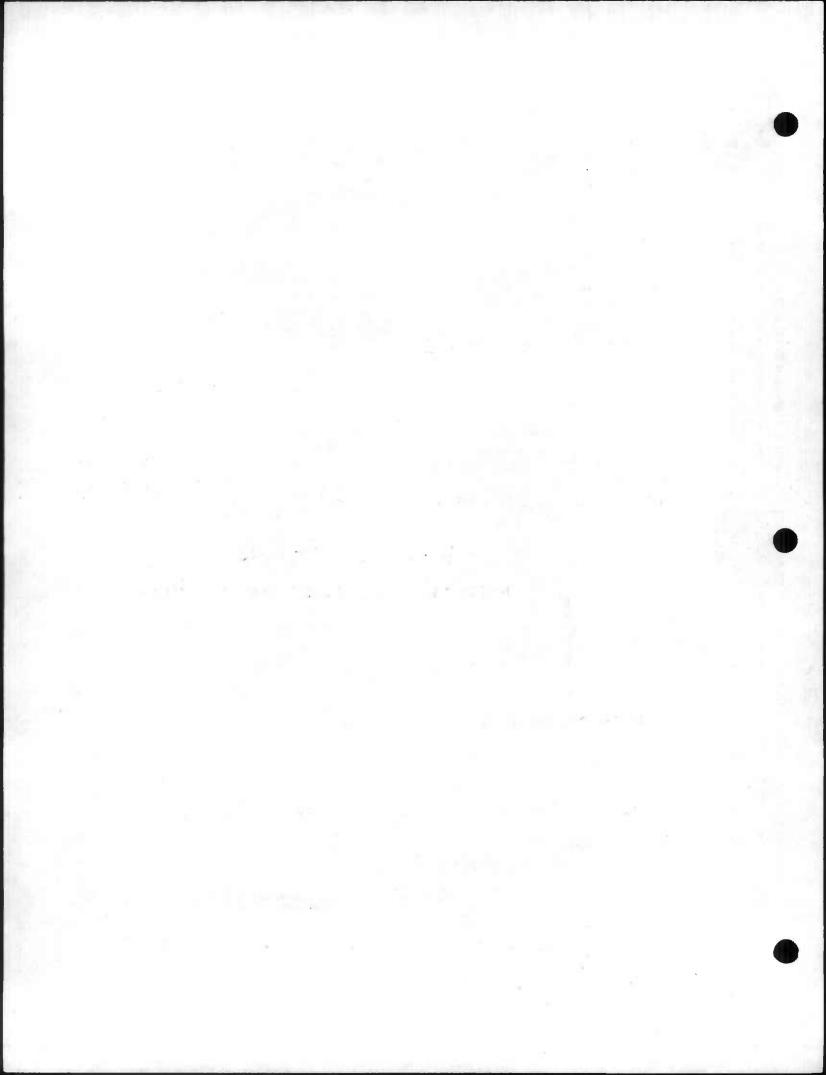
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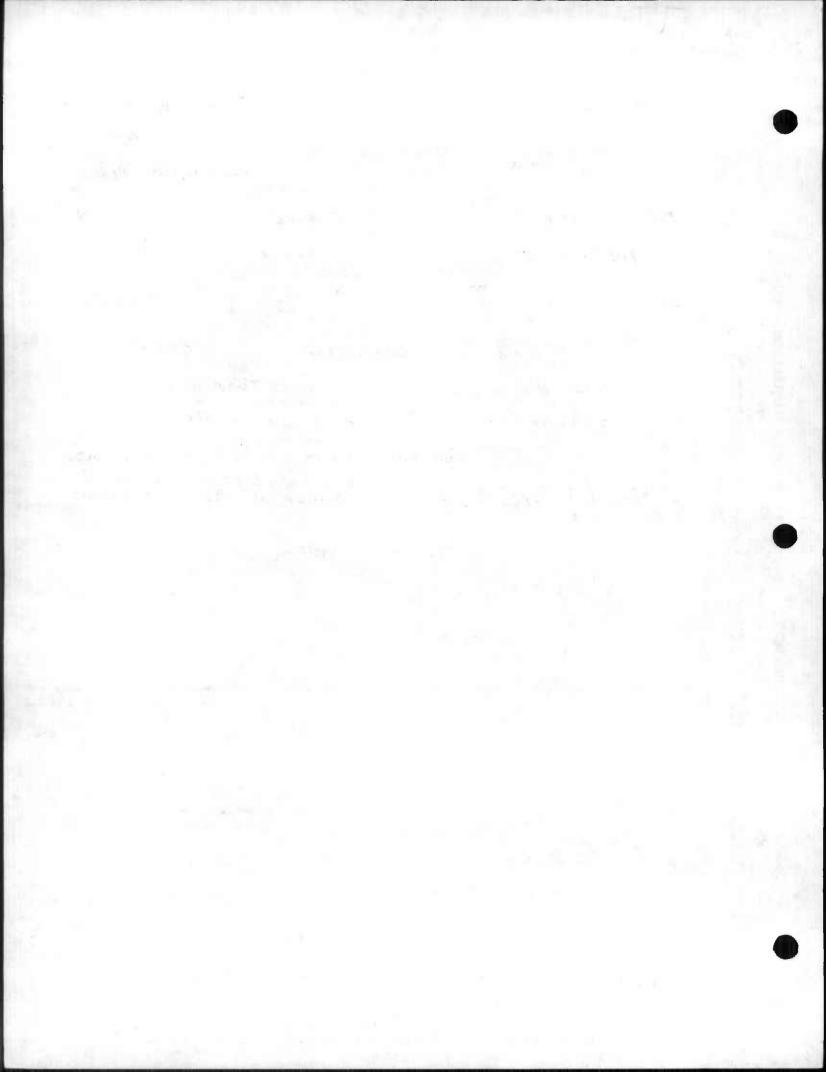
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within 24 hours
To the Funeral Completely filled

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21215-0020 d within 72 hours efter death with the Maryland glene. glene. "naturel", or frems 23a or 28a-f show than "naturel", or terms 23a or 28a-f show the Madical Examine must be notified.	P P	3.■ Widowed 4 Divorced 15. Decedent's Edu	Year or Detes:	16a	Decedent's Usual Occup	nation		16b. Kind of B				
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Division or Attending effer death. Director After	flca	3 Suicide 6 Could not be	28e. Plece of Injury	/ - At home, fa			28f. Location (S	treet end Numi	ber or Rura	al Route Number,		
DIV.	T e	4 Homicide	building, efc.	njury - At home, farm, street, fectory, office 28f. Locat fic. (Specify) 28f. Locat				cation (Street end Number or Rural Route Number, ty or Town, State)				
		29a. Certifier Certifying Physical Exami	sician: To the best of	my knowledge	, death occurred at the ti	me, date end place,	and due to the c	ause(s) and m	enner as s	teted.		
To the H within 24 To the Fa	edical	one)	end menner state	d.	d/or investigation, in my o							
To Tros	Σ	29b. Signature and title of certifier			29c. Licens		2	9d. Data signe	d (Month,	Dey, Year)		
		P Du Im	100		,	70854		10/	1/49			
		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Type, Print)	Saltman.	MD 2	1202				
Stat	6	31. Dete filed (Month, Day, Year)	32. Registrar's	s Signature-								
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State of Maryland / Department of Health and Mental Hygiene

ERIC TOWNES Certificate of Death Reg. No. 1. Decedeni's Neme (First, Middle, Last) 2. Dele of Deeth Month OCT. Dey **Physician** Eric Algeron Townes 7, 1999 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 500 BLOCK WINSTON AVENUE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 214-04-5098 8. Date of Birth (Month, Day, Year) 12-28-68 Funeral Months Days to M 2□F Director Usuel Residence of Deceden 10e Slete 10b. County 10c. City. Town or Location 28a-f ahow MD Baltimore Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 5003 Govane Avenue 21212 USA items 23a death 12. Wes Deceden! Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiens. Important: if Itan 27 is marked other than "natural", or item any injury or other traumatic avent, the Headest Expense. Bieck, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Janitorial Alpine Cleaning Co 11th Grade 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be William Carter Willie Mae Townes 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Willie Mae Townes 5003 Govane Avenue Baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 Cremetion 3 Removel Irom Stele Arbutus Mem. Pk. Cem. 10-12-99 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lipens 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. **Physician** /Medical Immediate Cause (Final GUNSHOT WOUNDS disease or condition resulting in death) Examiner physician and the burial-transit the death certificate be axecuted

Examiner Physician/Medical signed by t þ Completed Be P Certification:

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Box 68760.

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or Attending Physician:

Hospital

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Wes en autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death? 1 Yes 2 No

Approximate tntervel Between Onset end Death

3. Time of Deeth

Birthpiece (State or Foreign Country)

MD

10d. inside City Limits

X Yes 2□No

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25. Wes case referred to medical examiner? 1XX es 2 No 27. Manner of Death

1 Netural

2 ☐ Accident

3 ☐ Suicide

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury

that initiated events resulting in death) Last

1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Dev Yeer) 030TP

Due to (or es a consequence of):

Due to (or es a consequence of):

Other: 4 Nursing Home 5 Residence Worther (Specify) AT SCENE 28c. Injury et Work? 1 Yes 2 No

26. Place of Death (Check only one)

28d. Describe how injury occurred Sussour ups sider.

2 🗆 No

6 Could not be 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide STYEST

10-7-99

28f. Location (Street and Number or Rural Route Number, City or Town, State) 500 by unispa Dw. Brownsun

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end manner es stated.

X2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. (Check only one) 29b. Signetpye and title of certifier

5 Pending investigation

29c. License number O.C.M.E

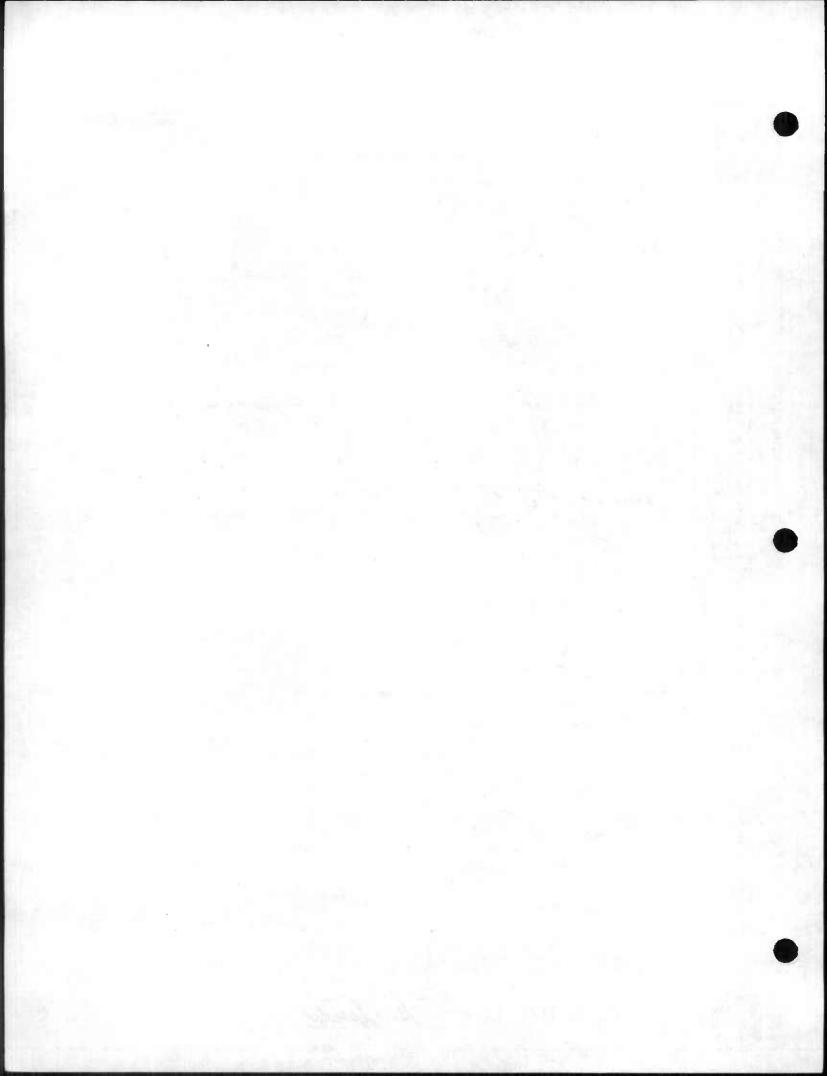
29d. Date signed (Month, Dey, Year) OCT. 7, 1999

Morrie 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print)

HAMADONOS A. W. Maryland 21201

State Registrar

31. Date liled (Month, Day, Year) OCT 12 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month THOMPSON TDA 0. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BonSecour Hospital Baltimore Birthplace (State or Foreign Country) If Undar 24 Hrs. If Under 1 Year 5. Social Sacurity Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days 1 M 2 F Months Hours 212-80-8290 86 04-09-13 SC Usuai Residenca of Decedent 10d. Inside City Limits 10e State 10h County 10c. City. Town or Location Yas 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2867 Woodbrook Avenue 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Black, White, etc. 1 Navar Married Z Married 1 ☐ Yas 2 🔯 No If Yes, Give Year or Dates: 1 Yas 2∑ No Specify: Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NA College (1-4or 5+) Elementary/Secondary (0-12) 2nd. Grade various trades Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Josephine Parker Charlie Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 2867 Woodbrook Avenue Baltimore, MD. 21217 Donald Thompson 20b. Piace of Disposition (Name of cemetery, crematory or other piaca) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cramation 3 □ Ramoval from Stata MD. Nat'l Mem.Pk. Cem.10-13-99 Laurel, MD 4 □ Donation 5 □ Other (Specify) 22. Nama and Address of Facility of Funaral Sarvice Licen Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue sairs Fattl/Enter tha disaasa, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, thook, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth immediate Cause (Final disease or condition resulting in death) uropathy Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sacral 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mopatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c, Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.O.

the death certificate be axecuted Division of Vital Records, or Attending ofter death. Director: Aft 24 hours efter Funeral Dire letely filled in b Hospital To the Hosp within 24 hou To the Fune completely fi

Physician

/Medical

Director

Funeral

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Completed

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filled within 72 hours after in and of Health and Mental Hygiene.
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Department of Important: If any Injury or once. ò

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Certification:

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29a. Certifier

(Check only

29b. Signature and titla of certifie

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0020

the Maryland

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death

State Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

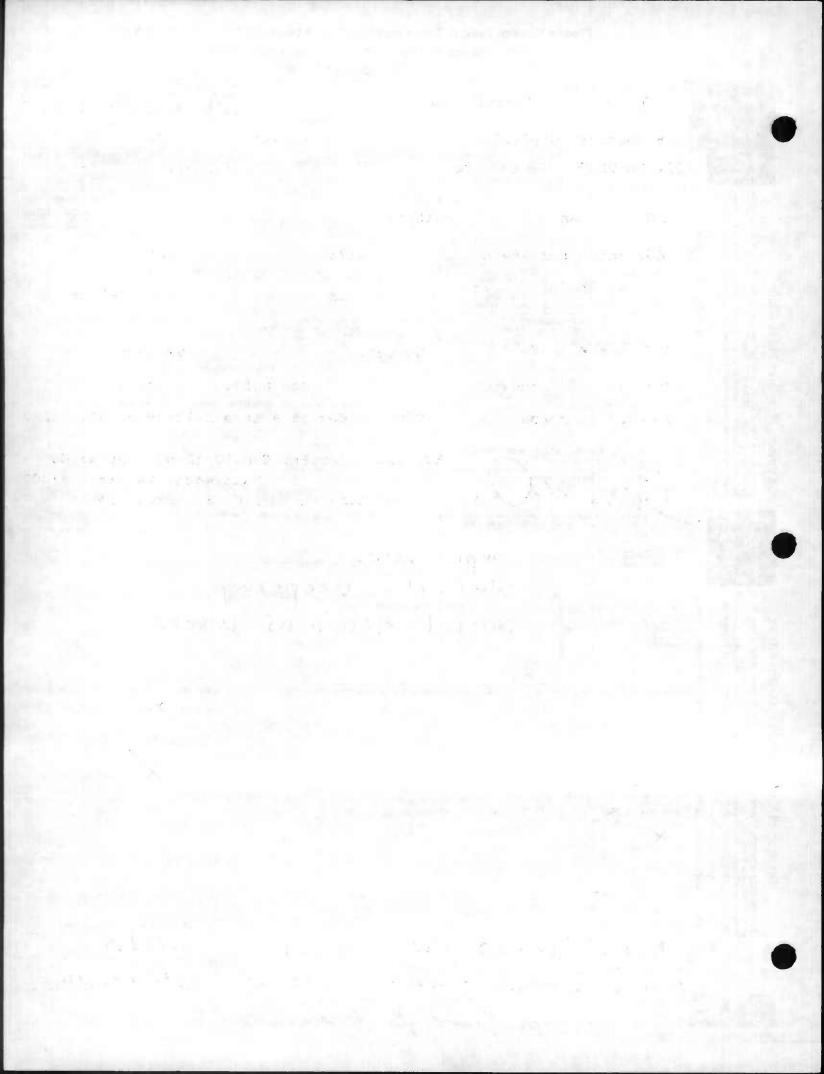
29c. Licensa number

D18327

4660 Wilken Ave 203 Balts Md 21229

29d. Data signed (Month, Day, Year)

DHMH 16 Ray 6/95



P.O. Box 68760. Records. **Physician**

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7 is marked other than "natural", or itema 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural, or item eny injury or other traumatic event, the Medical Exercises pages.

Physician /Medical

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Physician/Medical Examiner

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Certification:

Medical

3 ☐ Suicide

29e. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date liled (Month, Day, Year)

Baltlmore, Maryland 21215-0020

PH-Division of Vital or Attanding To the Hospital or Attanding within 24 hours effer death.

To the Funerel Director: Afte completely filled in by the fun

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Registrar **DHMH 16 Rev 6/95**

State

32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

MILITELLO, M.D. SHOCK TRAUMA 22 S. Greene ST. Batt. MD 21201

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29c. License number

1218667

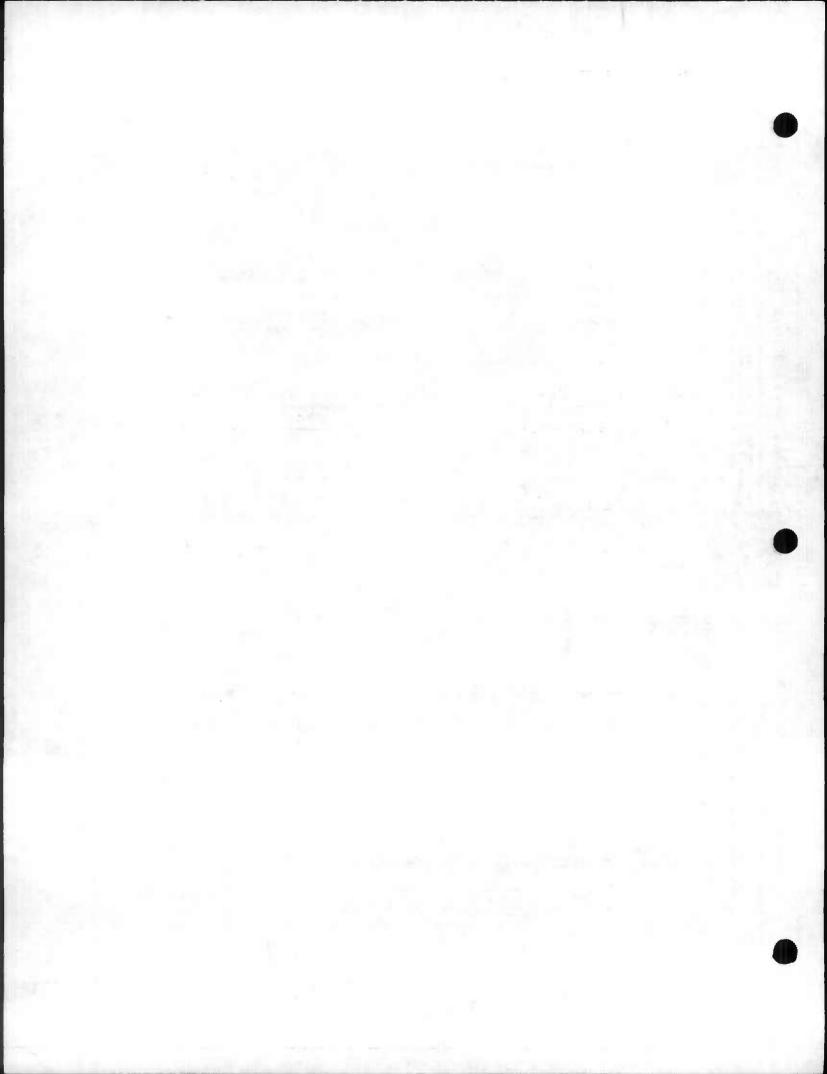
1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

ORIGINAL

28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Nama /First, Middle, Last OCTOBER! TRUE 8# 1999 MARY 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death Union Memorial Hospital N/A Baltimore 5. Social Security Number If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2⊠ F Months Days Hours Min Yrs. July 2, 1916 83 Ca. 553-10-7479 Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1K Yes 2 □ No Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4401 Roland Ave. Apt. 504 21210 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Professional Pianist Music 18. Mother's Name (First, Middle, Meiden Surname) 17. Fathar's Name (First, Middla, Last) Cmdr. Mark StClair Ellis Smythe Guenevere 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mrs. Marie T. Evans/daughter 4 Quail Hollow Rd. Lutherville, MD. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 10/12/99 Timonium, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Level 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death BIEEDING 4 HOURS Immediate Ceuse (Final disease or condition resulting in death) 3. YEARS Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 Yes 20 No 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Spacify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiane. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show way fujury or other traumatic event, the Medical Experies must be notified an once.

altimore, Maryland 21215-0020

Examiner Physician/Medicai þ

attending physician and for use as the burial-transit BS I Completed irector, page 2 s Be To this funaral Certification: After

The law requires that the death cartificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760.

that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was cese referred to medical examiner? Hospital: 1 Yes 2 No 27. Manner of Death 5 ☐ Pending investigation

2 Accident 6 ☐ Could not be 3 ☐ Suicida 4 Homicide

1 Unpatient 28a. Data of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier DEORGE HENNAWI, MD 29c. License number 2438946 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE HENNAWI, MD. THE UNION MEMORIAL HOSPITA 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

State Registrar

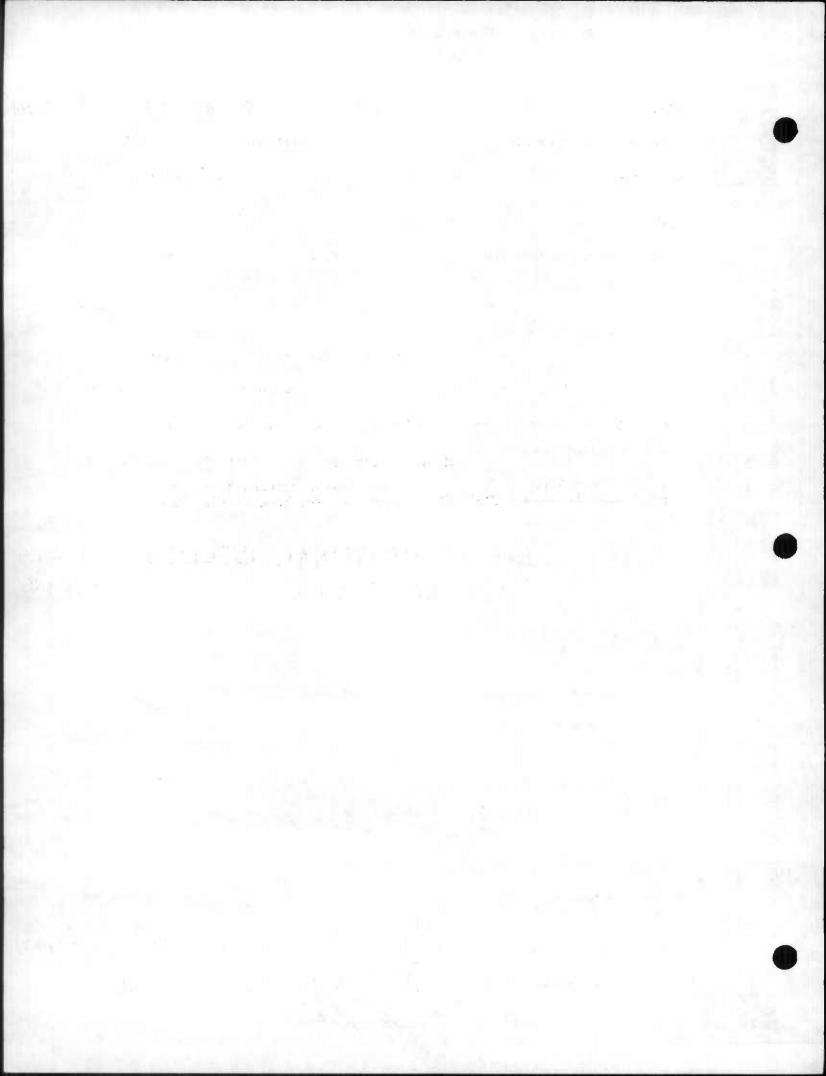
DHMH 16 Rev 6/95

within 24 hours after To the Funeral Direc complately filled in by To the Hospital

edicai

29a. Certifier

(Check only one)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death 1999gar 12:30 PM Turnbaugh October Pierce Walter 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Pikesville Hawthorne Avenue 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) 09-13-1918 5. Social Security Number 6. Sax 1 X M 2 ☐ F 7. Aga (In yrs. last birthday) 217-18-0978 Yes 81 Usual Rasidance of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. tnside City Limits 1 Yes 2 No Pikesville. Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. Hawthorne Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 11 Marital Status 14. Race - Amarican Indian, Black, White, atc. 1 XYes 2 No WW II If Yes, Giva Yaar or Datas: 1 ☐ Nevar Married 2 X Married White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) E. Stewart Mitchell Co Truck Driver n/a 10 Years 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Iva F. Young Charles E. Turnbaugh 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Hawthorne Ave. Pikesville, Maryland 21208 Elizabeth B. Turnbaugh (Wife) 20b. Place of Disposition (Name of 20a. Mathod of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 ☐ Cramation 3 ☐ Removal Irom State 10-8-99 Sykeville, Maryland Lake View Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) nore of Funeral Service Licensea 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland Wayne Osterling e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximata Interval Between Onset and Death Immediata Cause (Final disaasa or condition resulting in daath) Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaase or injury that initiated events resulting in death) Last as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case relarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Handsonon 6 Other (Specify) 218 No 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 Yes 2 No

P.O. Box 68760 Records, Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 **Чегта 23a**

natural", or

Hygiene.

and Mental Is marked of

permit. Peges 1 and 2: Department of Health ar Important: If Item 27 Is any Injury or other trace

Physician /Medical

Examiner

attending physician and for use as the burial-transit

signed by the

page 2

certificate

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

2 Accident 3 Suicide

4 Homicida

29b. Signature and title g

30. Nama and address

29a. Certifier

Peges 1 and 2 should be

within 72 hours after

altimore. Maryland 21215-0020

the Medical Examiner must be notified at

Directo

Funeral

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Completed

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requires that the death certificate be executed Division of Vital or Attending Physician: after death. Director: After this certific Hospital

> Registrar DHMH 16 Rev 6/95

To the Funeral D 24 hours a

To the Vithin 2

State

old Wonth, Day, Year)

8 Could not be

Zd 32. Registrac's Signature

of person who complated causa of death (Item 23a) (Type, Print)

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Bulto ME

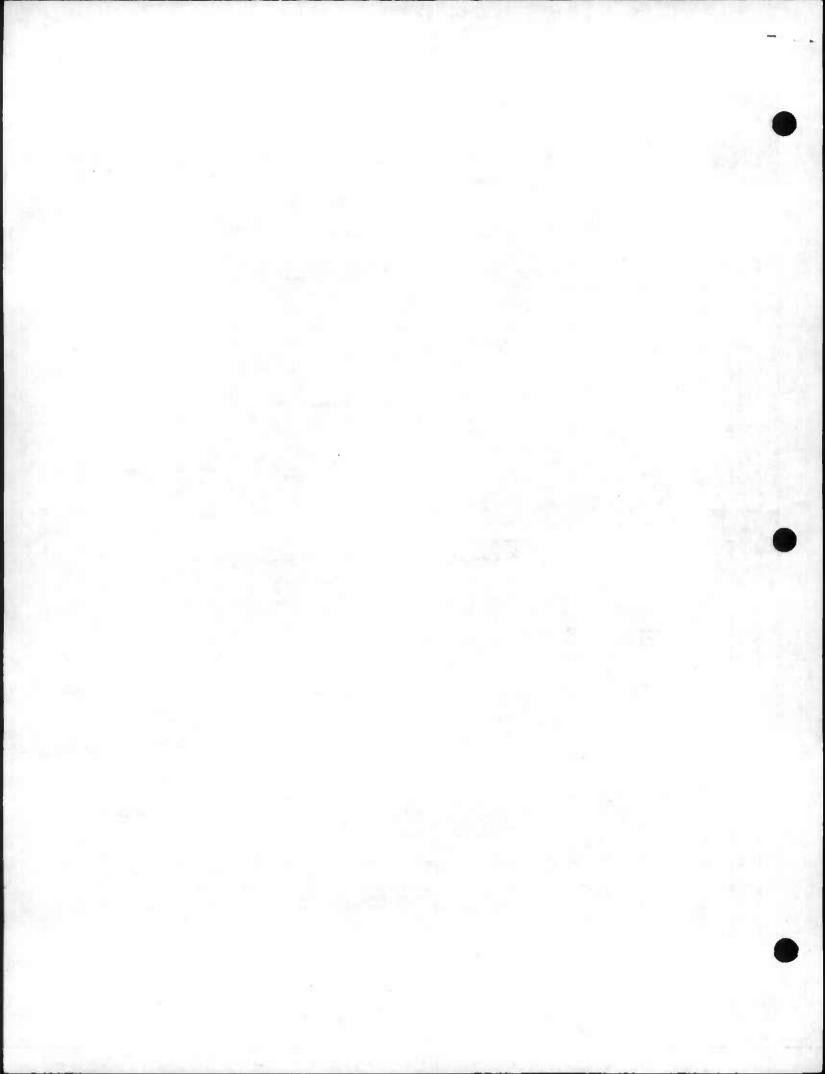
1 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

LOWS MACINON

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Data signed (Month, Day, Year)



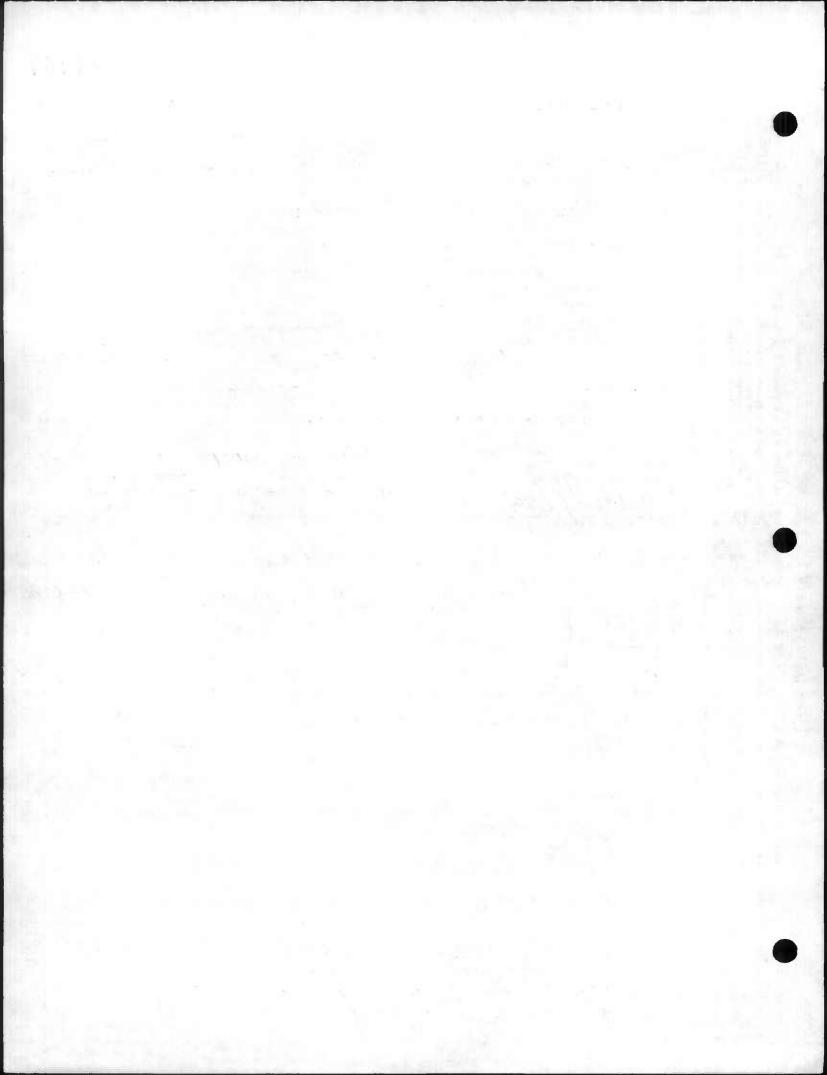
State of Maryland / Department of Health and Mental Hygiene

31767 Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death October Physician 8pm Robert Horace Vreeland /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** Days 1₺ M 2□ F Months 74 152-14-1310 Dec. 17, 1924 Director New Jersey Usual Residence of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Exempler must be notified at Maryland Baltimore Parkville 1 Yas 200No Directo 10e Street and Number 8820 Walther Blvd. # 2205 Belmont 10f. Zip Code 10g. Citizen of What Country? 21234 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1½ Yes 2 No WW II
If Yes, Give
Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hyglane.
Important: If Item 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Exemples Black, Whita, etc. 1 ☐ Never Married 2CXMarried Baitimore, Maryland 21215-0020 1 Yas 2₺ No Specify: Specify. þ 3 Widowed 4 Divorced White Korea Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Post Master n/a U.S. Postal Service 17. Father's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Lawrence Vreeland Julia Tucsnak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs. Adele C. Vreeland (Wife) 8820 Walther Blvd. # 2205 Belmont Balto. Md. 21234 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Data 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata Hollywood Memorial Park 10/11/99 4 Donation 5 Other (Specify) Union, New Jersey Towson, Maryland 21204 22. Name and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part f. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata tntarval Batween Onset and Daath Physician Immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Examiner Cardiovascular Disease the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medical Dua to (or as a consequence of): Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contributa to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown Insulin Dependent Diabetes Mellitus. þ 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vitai 25. Was casa refarred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours effer death. To the Funeral Director: After it completely filled in by the funera edical Certification: 28c. Injury at Work? After Division 5 Pending investigation 1 Yas 2 No 2 Accident 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 6 Could not be Place of Injury - Al homa, farm, street, factory, office building, atc. (Specify) 4 I Homicide **Decrifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certified 29c. License number 30 Nama and address of person who completed cause of death (them 23a) (Type, Print) SUSANG: WEIWE MD 8800 WILL No Parkville, Md 2/234. USan 31. Data filed (Month, Day, Year) 32. Registrar's Signature State **OCT 12** 1999 Registrar

AHB

Ireeland, Robert



AMEND IT	State of Maryland / SEM: #26 PER MD G776 10-12-99	Department of Health and Mental Hygiene Gertificate of Death Reg. No. 99 31760						
Physician /Medical	Decedent's Name (First, Middle, Last) Geneva Wiggins	2. Date of Death Month Day September 23, 1999 10:12 C						
Examiner	4a Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore 4c. County of Death n/a						
Funeral Director	5. Social Security Number 214-24-6620 Usual Residence of Decedent	Yrs. Months Days Hours Min.						
ith the Maryland or 28a-f show a notified at	10a. State 10b. County 10c. City, To	wn or Location 10d. Inside City Limits imore 1,2xes 2 □ No						
o after death with the Maryle or Herna 23e or 28a-f sho refree must be notified at Funeral Director	10e. Street and Number 2121 Windsor Garden Lane #A406	10f. Zip Code 10g. Citizen of What Country? USA						
15-002 n 72 hours "natural",	11. Marital Status 1 Never Married 2 Married 3 Now Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☑No Specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Bleck, White, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: Black						
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Omestic Services 16b. Kind of Business/Industry Phillips Family						
Baltimore, Maryland 212 pomit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mence. To Be Comp	17. Father's Name (First, Middle, Last) Willie Flemings	18. Mother's Name (First, Middle, Maiden Sumame) Hattie Bell Thomas						
e, Mar 1 and 2 sho Health and em 27 le m wher traum	Yvonne Brown 6.	th. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Pilgrim Road Baltimore, Md. 21214 of Disposition (Name of Date 20c. Location - City or Town, State						
Baltimorr	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbut	us Memorial Park Sept. 30 Baltimore, Md.						
Balti pemit. Departi Importe any Info	21. Signature of Funeral Service Licensee Helper E. Frutter	22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216						
When the principle of t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Approximate of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth August discussion of the Consequence o						
Box 6 seth certific seth certific partending professes for use as	Part II. Other significant conditions contributing to death but not resulting							
rds, P.O. quires that the de	Diabetes Ogresortinh's	1 Ves 2 No 3 Probably 4 Ohknow 24a. Was an autopsy 24b. Were autopsy findings						
The law requires the law requires the last has been signed, page 2 should be d	Congestive Heart Fai	performed? available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No						
Division of Vital I coptal or Attending Physicien: The Pubous after death. Financial Director: After this certificate pletchy filled in by the funeral director, pagedical Certification: To Be Coedical Certification:	25. Was case derived to medical examiner? 1	Time of Injury M 28c. Injury at Work? M 28c. Injury at Work? 1 Yes 2 No						
Div hours after hours after horse Directified in by lical Certif	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination a	pe, death occurred et the time, date and place, and due to the cause(s) and manner as stated. nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
Comple	29b. Signature and title of cuming	29c. License number 29d. Date signed (Month, Day, Year) September 20,1787 (Type, Print) WWD 1838 Coverne Tree Rd Suit 360 Baler Mod						
State Registrar	30. Name and address of person who completed chule of death (key, 23a Who Call) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	17 1838 CONCENC Tree Rd Suite 360 Balt Mia						

DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Nama (First, Middle, Last) Month Dey **Physician** 9, 1999 3:30PM October Ethel Marie Woolley /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Nama (If not institution, give street and number) Examiner Reisterstown 2333 Elderberry Lane 7. Aga (In yrs. last birthdey) Carroll If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Min. Months Days Hours 1□M 2☑F 76 Yrs. 220-20-7198 Usual Rasidance of Dacedant Director Nov. 28,1922 MD Pages 1 and 2 should be filled within 72 hours after death with the Maryland neat of Health and Mental Hyglene. In the Mental Physione with: If term 27 is marked other than "naturel", or items 23a or 23a-f show any or other traumatic event, the Medical Experience must be notified at 10a Stata 10b. County 10c, City, Town or Location 10d. inside City Limits 1 ☐ Yes 2√ No Director MD Reisterstown Carroll 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2333 Elderberry Lane 21136 USA Funeral 14. Raca - American Indien. 12. Was Decedant Evar In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11. Marital Status Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No If Yas, Giva X Year or Datas: Specify: White 1□ Yas 2⊠ No Specify: 3 ☐ Widowed 4 ☐ Divorced þ Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Collaga (1-4or 5+) Elamantary/Sacondary (0-12) Housewife Own Home 12 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be 0 Milton B. Gipe, Sr. Mary Smith 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Husband 2333 Elderberry Lane, Reisterstown, 21136 James C. Woolley 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data permit. Pages Department of Important: If it eny Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 10/11/99 Hampstead, MD Carroll Cremations 21. Signature of Funesal Service Doesse 22. Nama and Addrass of Facility 11824 Reisterstown RD Reisterstown, MD 21136 Fair the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, by heart failure. List only one cause on each line. Approximata Intarval Betwaan Onset and Deeth **Physician** 32 FIND Immediata Causa (Final disaasa or condition resulting in daeth) /Medical Examiner Due to (or as a consaquance of) Examiner physician end the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or es a consequenca of): signed by the e 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underiving cause given in Part I. Ö 1 Yes 2 10 3 Probably 4 Unknown Division of Vital Records, P. by 24b. Wara autopsy findings available prior to completion of cause of deeth? been si 24a. Was an autopsy Completed page 2 has 1 Yas 2 THO ils certificate h director, page 1 ☐ Yas 2 ☐ Yo Hospital or Attending Physicien: 25. Was casa rafarrad to madical axaminar?

1 Yas 2 No Be 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Masidanca 6 Othar (Specify) 20 1 Inpatiant 2 ER/Outpatient 3 DOA this funerel 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Matural 5 Panding 1 ☐ Yas 2 ☐ No invastigation death ector: A 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) ofter Direc 4 Homicida within 24 hours efter To the Funeral Direct completely filled in b 1 Certifying Physicien: To tha best of my knowledga, daath occurred at the tima, data and place, and due to the cause(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiai Medicai (Check o 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatu title of certifier 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) Westminster, MD 21157 Flavio Kruter, MD, 224 Washington Heights UCT 12 1999 32. Registrar's Signatura 9. Spouls State

DHMH 16 Rev 6/95

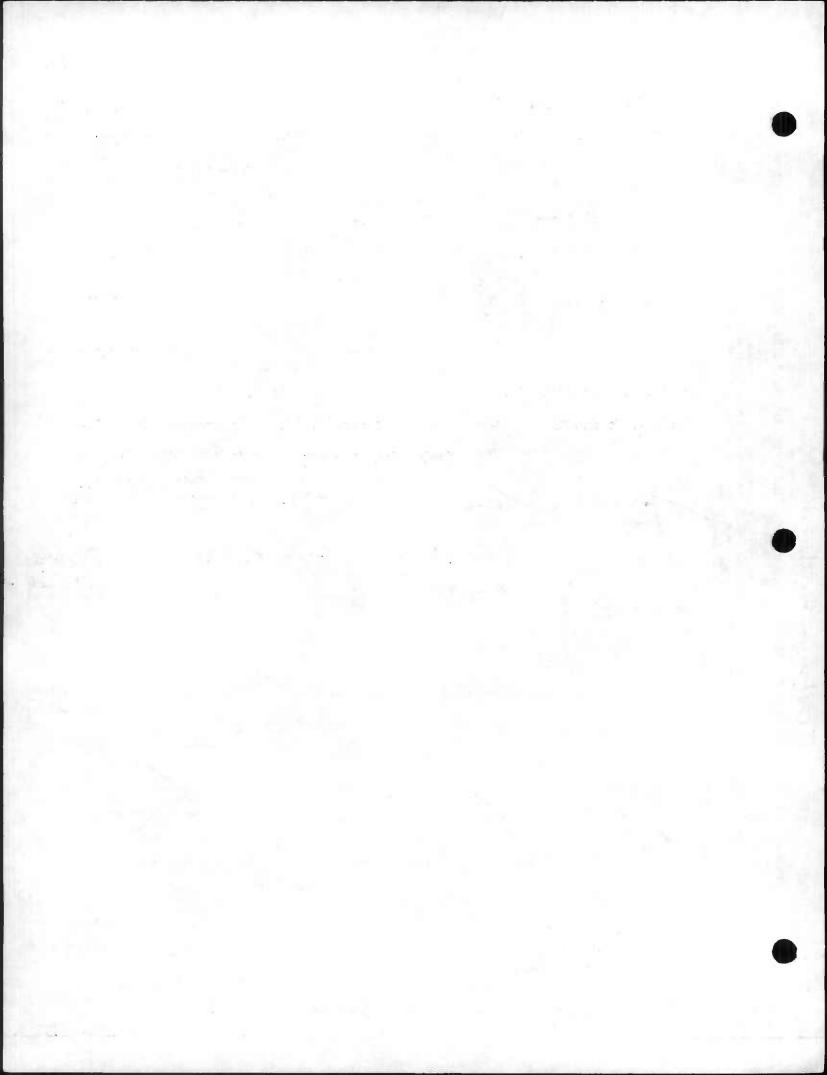
Registrar

HODELIN BUSHING

4P-11-01 10-11-94

State of Maryland / Department of Health and Mental Hygiene

			Certificate of	Death	Reg. No.	31/10		
Dhucisian	Decedent's Name (First, Middla, Last)			2. Data of Month		3. Time of Death		
Physician /Medical	Jeffrey S. Woodwo	rth		00	7-11-1999	1150		
Examiner	4a Facility Name (If not institution, give street			4b. City, Town, or Location of D	7.8			
	Levindale Hebrew Geri			Baltimore	Baltimo			
Funeral Director	5. Social Security Number 6. Sex 150 M 2	7. Age (In yrs. last bit	rthday) If Undar 1 Yaar Months Days	Hours Min. 8. Data of (Month)	(Birth , Day, Year) 9. Birth Co. 20, 1962	hplace (Stata or Foraign funtry) MD		
D Bud	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits		
Aaryli Paho	MD Baltimore		sterstown			1 ☐ Yas 2 ☐ YNo		
Sct Sta	10e. Street and Number	Reis	10f. Zip Code		10g. Citizen of What Co	untry?		
offer death with the Manyland free frees 23s or 28s-f show free must be notified at Funeral Director	501 Cockeysmill Rd.			21136	USA			
Urs after alf, or the by Full	1 Never Married 2 Married 1	is Decedent Ever in U,S. ned Forceş?] Yas 2 [2] No 'es, Giva ar or Dates:	13. Was Decement of P	dispante Origin? (Specify Yes or an, Maxican, Puarto Rican, atc. Specify:	Cassilan			
1 21215-0 ed within 72 ho yogiens, set then 'netur s, the Medical.	15. Decedent's Education (Specify only highest grade comp	15. Decedent's Education 16a. Decedent's Usual Occupation 1						
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Con the St	12							
D STAR O	17. Father's Nama (First, Middla, Last)	Idla, Maidan Sumama)						
Earylas 2 should b and Ments is marked summitte a	David L. Woodworth, J			Lois A. Met				
Man 12 and 15 an	19a. Informant's Name/Relationship (Type, Pri			and Number or Rural Route No				
G, No.	Lois A. Woodworth M	lother 50	Disposition (Nama of	11 Rd., Reiste	rstown, MD 2			
Pages went of	1 Deurial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	I from State	l Ridge Ceme	ce)	99 Pikesvill			
- 40744	21. Signature of Funeral Service Licensee	line	22. Nama and Addra	ral Home Reist	Reisterstown erstown, MD			
3	23a Pant. Enter the disease, or complication shock, or heart failure. List only one cause	s that ceused the death. Do				Approximata Interval Batween		
Physician /Medical	Immediata Cause (Final	le 1 . 1 -		tiple sile		Onset and Death		
	disease or condition a	Eddis	Tyeas					
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J	b	sepsis			i i	7/0000		
S, emouted in-transit Examin	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury c.	Due to (or as a	consequence of):					
1 99 2 5 T	Cause (Disease or injury that initiated events							
Post of Physics and Physics an	resulting in death) Last	Dua to (or as a	consequence of):		1			
	d							
Pan de de de de de de de de de de de de de	Part It. Other significant conditions contributing	on to death but not resulting i	n the undertying cause give	ven in Part I 23h I	Did tobacco use contribute	to the cause of death?		
P.O. Box that the death ce ed by the attends detached for use		y to total sol not resulting i	n ale shootlying caosa giv			robably 40 Onknow		
Of Vital Records, Physician: The law requires it this certificate has been signe rail director, page 2 should be of			5.0		performed?	Were autopsy findings available prior to completion of cause of death?		
I Re law the law page 2								
C the state of the	OF Was note referred to medical	,				1 ☐ Yas 2 ☐ No		
of Vita Physician: this certific ral director. To Be	25. Was case referred to medical examiner? Hospita	1	oth oth	26. Place of Death (Check or		214.1		
Par Physical Company	ILI Tes 214/NO	1 Pinpatient 2 ER/O	stpatient 3LI DOA	4 Nursing Homa 5 F	Rasidence 6 Other (Specifibe how injury occurred	ziry)		
for the form	T published to the state of the	(Month, Day Year) 28b.	Injury Wor	rk? Yas 2□No				
Division of an an art death at Director, Altar the transfer of in by the funer of certification:	2 Could not be	Place of Injury - At home, fa building, atc. (Specify)				ıral Routa Number,		
A hour furner lasy fill	(Check only 2 Medical Examiner: Or			me, date and place, and due to pinion, death occurred at the ti				
Med	29b. Signature and title of certifier	o mainar stateu.	29c. Licens	se number	29d. Date signed (Monti	h, Day, Year)		
F 1 1 8	Malledanin		N 10	41011		1559.		
N	- Washing		2 4	4 (1)	100.12	21215		
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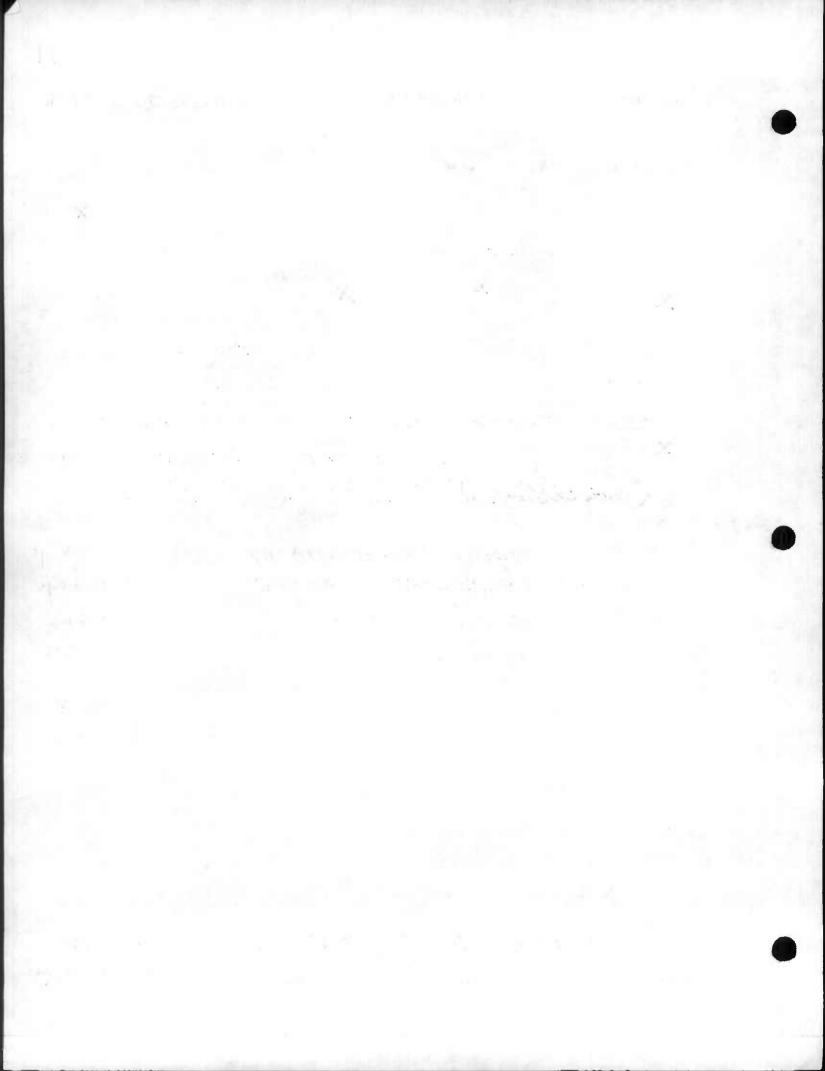
State of Maryland / Department of Health and Mental Hygiene 99 31771

						Ce	ertificate d	of Death	R	eg. No.) (
	Physicia /Medic		1. Decedent's Neme (First, Midd ANTHONY	le, Last)	inc	SAT	E		2. Dete of Dea Month	Dey	Year 1999	3. Time of Death 17:50
	Examina Funeral	er	5. Sociel Security Number	SPITAL	ge (In yrs.	last birthday	/) If Under 1 Ye Months De	BALTI	8. Dete of Birth	4c. County N/	9. Birthpl	ace (Stete or Foreign
-	Director		216 62 2006 Usuel Residence of Decedent		44				NOVEMBE	R 14,199		ARYLAND
	a Maryle ta-f ebov	ctor	MD . 10b. County		10c. Cri	BAL]	CIMORE				10	Od. Inside City Limits Yes 2 No
	death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 1224 W. LAFAY	ZETTE AVEN	UE		10f. Zip Cod	217		0g. Citizen of t		
020	urs after	P	11. Merital Stetus 1 Never Merried 2 Mer 3 Widowed 4 Divorced	M Man Olive	No.	,S. 13	Was Decedent If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- rto Rican, etc.)		ce - America ck, White, e	
21215-0020	n 72 ho	Completed	15. Deceder (Specify only higher Elementery/Secondery (0-12) 1 2 T H	nt's Education est grade completed) College (1-4or UNKNOWN	5+)	(Giv life.	DO NOT use re	ne during most of wo		16b. Kind of B		
Maryland	H dot	To Be C	17. Father's Name (First, Middle, MASON WINGAT						me (First, Middle, i	Maiden Sumen		
lany	d 2 should th and Men T la marke traumatic		19a. Informent's Neme/Reletions	ship (Type, Print)		19b. Mai	ling Address (Str	eet end Number or R	iural Route Number	City or Town,	Stete, Zip	Code)
	ges 1 and to of Haalt if Item 2 or other		20a. Method of Disposition 1 Burial 2 Cremation		20b. F	Plece of Disp cemetery, cri	position (Neme of emetory or other	piece)	Dete	20c. Location -	City or To	
Baltimore,	pemit. Pa Departmen Important: any Injury poce.		4 Donetion 5 Other (5	Licens EWIS T				dress of Fecility T. GWYNN	FUNERA	L HOM		MARYLAN 215-6393
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	/Medical Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)		Due to (d	or as e cons	equence of):	LOPATH	,		i	6 days
	outed nd ransit	Examiner	Sequentially list conditions.	RESP			equence of):	AILURE			6	days
68760,	sician a	Sal Ex	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	. SEP	Tic	-	Sitoci	<			a	IEEKS
Box 687	eath certificate be asscuted ettending physician and for usa as the burial-transit	n/Medical	resulting in death) Last	, PNE		on as a conse					u	VEEKS
, P.O. B	at the d	by Physician	Pert II. Other eignificant conditi	ons contributing to death I	but not res	ulting in the	underlying cause	given In Pert I.		obacco uae co ea 2 No	ntribute to	the cause of death?
9	2 8 8	Completed b							24a. Wes e perfor		ava	ore eutopsy findings allable prior to appletion of cause death?
E E	ysician: The is cartificate he director, page	် ပ							1 🗆 Y	es 2 No	1	Yes 2 No
=======================================	cartificate irector, pa	1	25. Was case referred to medica examiner? 1 Yes 2 No	A to destroy all of				Other	eth (Check only or	-		
ion of	Attanding Physician: r death. octor: After this cartific by the funeral director,	ation: To	27. Manner of Death 1. Netural 5 Pendir 2 Accident investi		Ury	28b. Time Injury	of 28c. I	njury at Work?	Home 5 Residence 128d. Describe h)
Divis	× 2 = c	Certification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Plece of In building, e			treet, fectory, offi	Се	28f. Location (S. City or Town		ber or Rura	Route Number,
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	Tot V	Σ	29b. Signeture and title of certifie A , \mathcal{J} .	Heloy M	6.	*	29c. Lio	ense number	5	9d. Date signe	d (Month, L)ay, Year) 1999
-	W		30. Name and address of person ARDALLAH J. 31. Date filed (Month Pay Year)	Heloy M who completed cause of HELOU, M.	death (Item	CHUR	Print)	SPITAL,	00 N. BRO.	ADLAY	BALT	IMOR MA 21231

DHMH 16 Rev 6/95

Registrar

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #19b PER FH G776 10/12/99 AH 3. Time of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death Month **Physician** 6 1199 4c. County of Death 2:40 Ed war /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not ipstitution, give skeet and number) **Examiner** Bon Ecours Wi Ba TIMOVE TA If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) 5. Sociel Security Number 6. Sex **Funeral** Months Days Hours Min 12 M 2 F a 18-36-9999 Usual Residence of Decedent Yrs. Director Nevember 21,1937 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Baltimore 10 Yes 2 No Directo NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? aldi 928 permit. Pages 1 and 2 should be filed within 72 hours effer death vibrograms of Health and Mentel Hygiena.
Important: if filem 27 is marked other than "natural", or flems 23e and injury or other traumatic event, the head Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cubap, Mexicen, Puerto Rican, etc.) American Indien 14. Race -11. Meritel Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No f Yes, Give Year or Dates: Specify: Blac p 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DQ NOT usa ratired) Elamentary/Secondary (0-12) College (1-4or 5+) +K abover Indus. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maldan Sumama) Be ene an 19b. Mailing Address (Street and Number of Ryral Route Number City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) CANY Macheal THE HIMOYY IMDAIDAT 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date (timore) 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Cary P. March
270 Fredhilton 21. Signature of furtiers Service Licensee Home FUNEYUI 21229 Pess 270 Finer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition resulting In death) Mark Examiner Due to (or as a consequence of) Examiner The law requires thet the death certificate be axecuted Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) attending physicien for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of) 88 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings eveileble prior to 24a. Was an autopsy Completed peed completion of cause of death? hes 1 Yes 2 No 2□ No this certificete Physician: 25. Was cesa referred to medical examiner? Be 26. Place of Death (Check only ona) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Pinpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b Time of 28c. Injury et Work? Certification: within 24 hours efter death. To the Funeral Director: After or Attending 1 Natural 5 Panding Investigation 1 Tas 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Spacify) filled in by 4 Homicide Hospital 29a. Cartifian edical 1 🗹 Certifying Physician: To tha best of my knowledga, daath occurrad at the tima, data and placa, and dua to tha causa(s) and mannar as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

Secours Huzity

29d. Date signed (Month, Day, Year)

2

State

29b. Signature and title of certifier

MARCOS

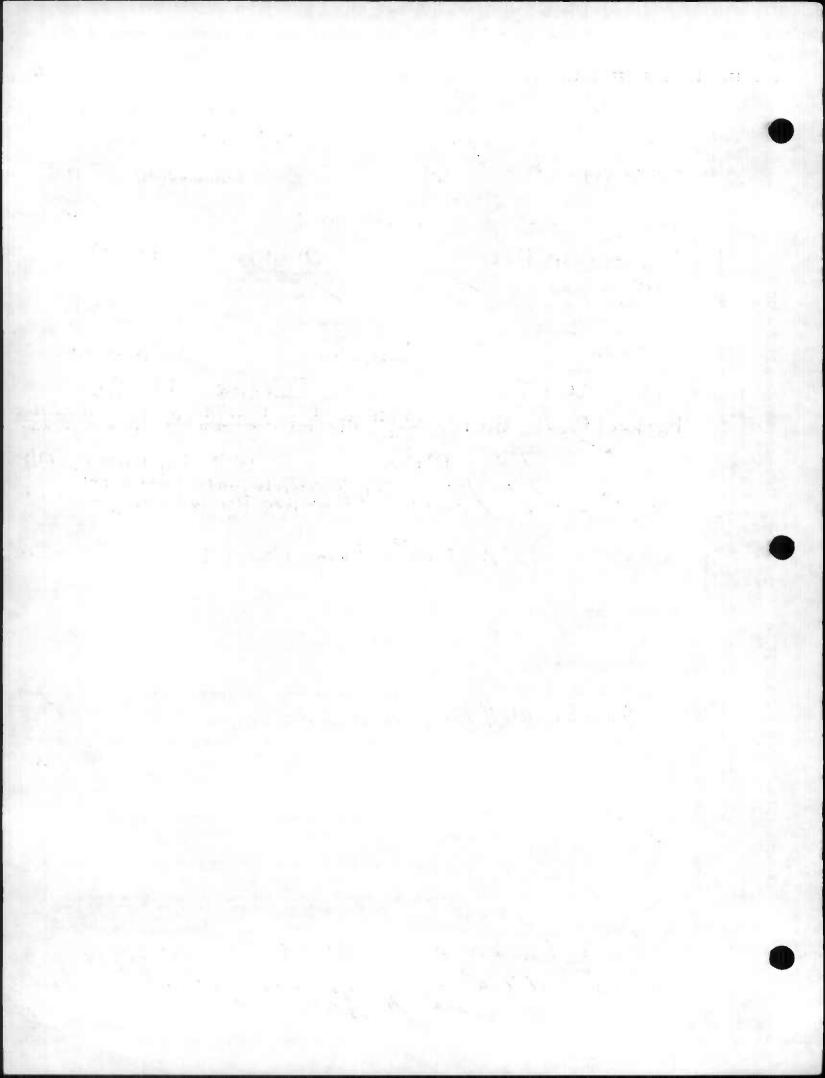
OCT 12

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

61614

32. Registrar's Signature

Registrar



State Registrar

Word Wm 111 Penn Street, Baltimore, Maryland 21201 HAMPRION A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

29b. Signature and title of certifie

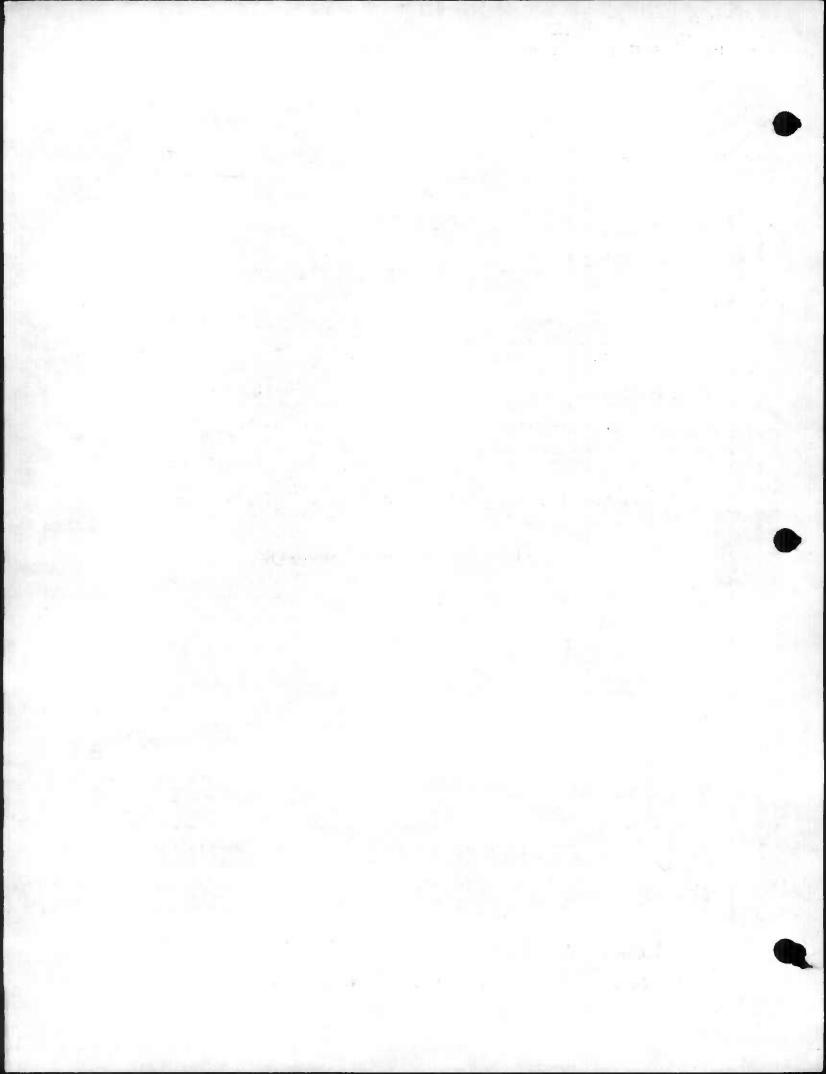
29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year) OCT. 4, 1999

OCT 12 1999

ass of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death Reg. No. 2. Date of Death Month Day Year

Physici /Medi Examir	cal
Funeral Director	
aryland	

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: if item 23 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be inclined at pince.

To Be Completed by Funeral Director

Permit. Pages 1
Department of H
Important: If Iter
Examiner any Injury or ord

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the burlet-transit

Division of Vital Records, P.O. Box 68760,

State
Registrar

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1 	1. Decedent's Name	e (First, Middle, La	1 1 .	- K. E. Y	2	JR.	lem 4	2. Date of Do Month		ay /	999	3. Time of Death
r	4a Facilify Name (I	f not institution, giv	e street end number)				4b. City, Town, o	r Location of Dea	th 4	c. County	of Death	
	VETER	IANS A	Idminist	ahm	HOSK	pital	Bal	timere		N/	Ά	
	5. Social Security N			e (In yrs. lest	birthday	If Under 1 Year Months Days			irth	r)	9. Birthp	place (Stete or Foreign
	237 34 5	5191	M 2□ F	75	Yrs.	Months Days	Hours Mil	Feb. 2		924	Nor	th Carolin
	Usual Residence of	Decedent		,								
	10a. State	10b. County		10c. City, T							1	10d. Inside City Limits
	Maryland	Anne Ar	unde1	Ba1t	imore	9						1 ☐ Yes 2 ☑ No
Ì	10e. Streef and Nur	mber				10f. Zip Code			10g. C	itizen of \	Vhat Cour	ntry?
	5703 Fra	anklin St	reet 2nd	Floor		2122	25			U.S		
1	11. Marifal Sfafus		12. Was Decedent	Ever in U.S.	13. W	as Decedent of	Hispanic Origin?	Specify Yes or N	0-		-	can Indian,
1		ed 2 Married	Armed Forces?		If	Yes, specify Cub	oan, Mexican, Pue	erto Rican, etc.)		Blac	k, White,	etc.
,	3 🗆 Widowed		If Yes, Give Year or Dates:	W.W. I		☐ Yes 2M2 No	Specify:			Specify	": Wh	nite
ŀ		15. Decadent's Ed				ent's Usual Occu	nation		16b.	Kind of B	usinass/in	
		ify only highest gre	ede completed)		(Give I	ind of work done	duning most of w	rorking	100.			
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	Tr. Fathar Strama		aul H. Wai	lkor S	~			Juanita N			,	
ŀ	19a. Informant's Na						t and Number or I					
ŀ		lker / wi	.te				Street	1	Y			nd 21225
1	20a. Method of Disp		Removal from State	cem	e of Dispos etery, crem	ition (Name of etory or other pla	ace)	Date	20c.	Location -	City or To	own, State
		5 ☐ Other (Specif		Hill:	top S	ervice (Corp.	10/12/99) T	OWSO	n, Ma	aryland
Ì	21. Signal Fu	neral Service Licer	nsee		1 22.	Name and Addr	ess of Facility	Conce 1	7	1	Taura a	D 3
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ı			Pn	eumo	in	a					1	
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ı			d									
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ı	Part II. Othar signiii	cant conditions o	contributing to death t	out not resultin	ig in tria un	denying cause g	IVOITIII FAILI.			11	3 □ Pro	
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ı								24a. Wa	e an aut	onev	24b. W	are autopsy findings
l									formed?		av	vailable prior to ompletion of cause
l										,	of	death?
								1□	Yes	No	1	☐ Yes 2☐ No
	25. Was case refer	rad to medical					26. Place of D	eath (Check only	one)		-	
1	examiner?	No	Hospital: Inpati	ant 2 ER	/Outpatient	3 DOA	ther: 4 Nursing	Home 5 ☐ Res	sidenca	6 □Oth	er (Speci	fy)
ľ	27. Mannar of Death	h	28a. Data of Inju		b. Time of	28c, Inju	ury at	28d. Describe	how in	jury occur	red	
1	1 Matural 2 ☐ Accidant	5 Panding investigation		sy rear)	Injury		Yes 2 No					
l	3 Sulcide	6 Could not b	e nee Place of In	iurv - At homa	, farm, stra	at, factory, offica		28f. Location	(Streat	end Numi	per or Run	el Routa Number,
	4 Homicida	datarmined		tc. (Specify)	,			City or To	own, Ste	te)		
1	29a, Cartifiar	10 Carlibdan Ch	ysician: To the best	of my knowle	dae dest	nontred at the t	ima data and sta	ca, and due to the	a cause	e) and m	anner ee	stated
١	(Check only	2 - Medical Exar	niner: On the basis of	of examination	and/or inv	estigation, in my	opinion, death oc	curred at the time	, date a	nd place,	and dua t	to the cause(s)
	one)	title of an ellin	and manner st	ated.		200 Licon	ise number		204 [ate ciono	d (Month	Dey, Year)
1	29b. Signature and	title of certifier	1	1	1 1	29C. LICON	ise number	7 -7	29U. L	ate signe	/ wonin,	00
	VII	6 /	Schauce	_ /	11)	P	135	++		101	111	91
1	30. Name and addre	ess of person who	completed cause of	death (Itam 23	Ba) (Type, I	Print)				-		
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illia	m Wil	SC	State of Maryland / Department of Hea	alth and Mental		99 31775
4	Physicia: /Medica Examine	n il	1. Decedent's Name (First, Middle, Last) Wilson Jr. 4e Facility Name (If not institution, give street and number) 1.908 Christian Street	2. Dete Mont Octo City, Town, or Location of Baltimore	ober 04	Year 1999 02:13 AM unity of Death N/A
Dir	ineral rector		5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year	If Under 24 Hrs. 8. Date (Mont	of Birth h, Day, Year)	9. Birthplace (State or Foreign Country)
5-0020 72 hours after death with the Maryland	offind at	Ctor	10a. Stele 10b. County 10c. City, Town or Location Maryland N/A Baltimore		10.00	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
death with t	Herms 23a or 28a-f show free must be notified at	<u>a</u>	10e. Street and Number 1925 Freder: ck Ave 2122 11. Meritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, I		45	Race - American Indien,
5-0020 72 hours after	al', or la	2	1 Never Merried 2 Married 1 Yes 2 No	Specify:	Sp	Bleck, White, etc. ecity: Black of Business/Industry
2121 ad within giena.	er than 'natur t, the Medical	Completed	(Specify only highest grade completed) Elementery/Secondary (0-12) 7 +h (Give kind of work done dun life. DO NOT use retired) Mover	ring most of working	Mov	ingtHauling
C 0 7	to be	en o	17. Father's Neme (First, Middle, Last) William Harrison Wilson Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and	8. Mother's Neme (First, M /a dy 5 d Number or Fural Route N	Collin	5
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	any Injury o		4 □ Donation 5 □ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of	of Fecility Dougle	ss Fun	fimore, M.D. werul Service ore, MD121217
	sician		23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, shock, or heart tellure. List only one cause on each line.			Approximete Interval Between Onset and Death
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60,		ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			9 - J. B.
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P.O.	00		Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I. 23b.	Did tobacco use	no 3 Probably 4 Unknown
Sord requir		Completed by		24a.	Wes an autopsy performed?	24b. Were autopsy findings evailable prior to completion of cause of death
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ath.	he funaral di		1	es 2 No 28d. Desc	cribe how injury of	
the Hospital hin 24 hours	To the Funeral Directo	edicai	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, control of the control of t			d manner es steted.
Toth	Tor 1	2	4	.M.E.		igned (Month, Day, Year) tober 4, 1999
	State		31. Date filed (Month, Day, Year) 32. Registrer's Signeture	treet, Baltin	nore, Mai	ryland 21201
	Senistra:	_	OCT 12 1999 Director B. Spark	2		

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State of Maryland / Department of Health and Mental Hygie

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ene							

29d. Date signed (Month, Day, Year)

OCTOBER 5,1999

Certificate of Death 2. Data of Daeth 1. Decedant's Name (First, Middle, Last) Month OCTOBER 5, 1999 **Physician** DOROTHY WATTERS 8:50 AM /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner TOWSON GILCHRIST CENTER BALTIMORE If Under 24 Hrs.
Hours | Min.

8. Deta of Birth
(Month, Dey, Year If Undar 1 Yaar 5. Social Security Number 9. Birthplaca (State or Foraign 6. Sex 7. Aga (In vrs. lest birthdey) **Funeral** Months Days 1 M X F 218-36-3520 92 06-05-1907 PENNSYLVANIA Director Usual Rasidence of Dacedan should be filed within 72 hours after death with the Marylend of Meniel Hygiena.

marked other than "natural", or items 23a or 28a-f ehow 10d Inside City Limits 10e State 10h County 10c. City, Town or Location 7 le marked other than "natural", or items 23a or 28a-f ehov traumatic event, tre Modical Examinat must be notified at MD. BALTIMORE RUXTON 1 Yas XXNo Director 10e. Street and Numbe 10f. Zip Code 10g. Citizan of What Country? 1402 MALVERN **AVENUE** 21204 U.S.A. Funeral 14. Race - Amaricen Indian, Bleck, Whita, atc. 12. Was Dacedant Evar In U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas XXNo If Yas, Give 1 Navar Marriad 2 Married 1 ☐ Yas XXNo Specify: Baltimore, Maryland 21215-0020 Specify: WHITE P XXWidowed 4 ☐ Divorced Year or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) EDUCATION TEACHER YEARS 17 Father's Name (First Middle Last) 18. Mothar's Nama (First, Middla, Maidan Surname) permit. Pages 1 end 2 should be flie Department of Health and Mentel Hy Important: if them 27 le marked oth any linjury or other traumatic event DDSs. CLARENCE WOLFE OLA SPENCE 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 1402 MALVERN AVENUE, RUXTON, MARYLAND, 21204 ANN W. COLLINS (DAUGHTER) 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burial XX Cramation 3 Ramoval from State GREEN MOUNT CREMATORY 10-6 BALTO., MD., 21202 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility
HENRY W. JENKINS AND SONS COMPANY 21. Signetura of Funaral Service Licansee 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 uti 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onsat and Death Physician STAGE C.O. P.D END /Medicai Immediata Causa (Final MONTHS disaasa or condition resulting in death) Examine Due to (or as a consaquance of) Examiner physician end the burial-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting In death) Last Due to (or as a consequance of): Box 68760. Physician/Medicai Dua to (or as a consequance of): SB the attending 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part i. P 1X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Ware autopsy findings available prior to Completed 24a. Was an autopsy performed? been s complation of cause of daath? has 1 ☐ Yes X2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: after deeth. funeral director. Be 25. Was cesa raterred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence XXIOther (Specify) HOSPICE 1 Yas XIXNo 1 Inpatiant 2 ER/Outpatient 3 DOA Certification: To After this 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred XX Natural 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant To the Hospital or Attend within 24 hours after deeth To the Funeral Director: 6 Could not be detarmined 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) filled in by 4 Homicida 29a. Cartifiai XXCertifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and dua to tha cause(s) and manner as stated. edical completely 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

NZE, M.D., 7801 YORK ROAD, TOWSON, MARYLAND, 21204 31. Data filed (Month, Day, Year) 1 2 1999

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

29b. Signeture end titla of certifier

Key mmd

32. Registrar's Signature

M zuns

29c. Licanse number

E181 1-832-se 1381-88-se THE TAX OF A PROPERTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY. SERVICE THE STATE OF THE STATE de to be to the three to the

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Data of Daeth 3. Tima of Death 50AM Dey Month **Physician** Ernestine T. Wheeler ctober 8. 4c. County of Death * /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) Examiner altimore City Maryland If Undar 24 Hrs. 8. Dete of Birth Month, Dev. Yaar) OCt. 11, 1918 General if Undar 1 Year 5. Social Security Number Birthplaca (Stata or Foraign Country) **Funeral** Deys Months 1□M 2♥F 303 16 9676 Indiána **Director** Usual Residence of Dacedant filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits r 28a-f show show 1 ☐ Yes 2 No Maryland | Baltimore Directo Edgemere 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code Pagas 1 and 2 should be filed within 72 hours after daath with nant of Haalth and Mental Hygiena. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examinat must be a 21219 8007 Dogwood Rd. USA Funeral Expostine Wheeler Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - Amaricen Indian, Black, Whita, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Never Married 2 Marriad ☐ Yas 2 🛣 No f Yes, Giva 1 ☐ Yes 2 No Specify: White P 3 X Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondery (0-12) Collega (1-4or 5+) 12 Housewife Own Home 17. Fethar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surnema) Be Ernest Loucks Thersa Neuling 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Richard Wheeler (Son) 8007 Dogwood Rd. Baltimore, Md. 21219 20b. Place of Disposition (Nema of 20c. Location - City or Town, Stete 20a. Mathod of Disposition cematary, cramatory or other placa) 1 Burial 2 Cramation 3 Ramoval from Stata Md. Veterans Cemetery 10/13/1999 Garrison Forest, Md. **Departmant** 4 ☐ Donation 5 ☐ Othar (Specify) Tunerai Sarvice Licensee 22. Nama and Address of Facility Bruzdzinski Funeral Home P.A. Old Eastern Avenue Essex, Md. 21221 Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat end Death Physician /Medical immediata Causa (Final diseesa or condition resulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examine requires that the death certificate be axecuted physician and s tha burial-transit Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disease or injury that initiated execution) RUSEPSis that initiated evants rasulting in death) Last Dua to (or as a consequanca of): attanding pt signed by the a d be datached f Part II. Other eignificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of geeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ementia by 24b. Wara autopsy findings eveilable prior to 24a. Was an autopsy Completed completion of ceuse of death?

cartificate has b lirector, paga 2 s or Attending Physician: this funaral After

Division of Vital Records, P.O. Box 68760, 24 hours

Be

To

Certification:

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edical State Registrar

2 Medical Examination on the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and fifte of certi

5 Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA

28b. Tima of

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

1 ☐ Yas 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, deta end plece, and dua to the cause(s) and manner as stated.

29d. Data signed (Month, Day, Year)

1 ☐ Yas 2 ☐ No

Location (Street and Number or Rural Routa Number, City or Town, Stete)

1 Tes

28d. Dascribe how injury occurred

Go Maryland General Hospital.

Other: 4☐ Nursing Homa 5☐ Rasidence 6 ☐ Other (Specify)

28. Placa of Death (Chack only ona)

2 17 No

person who completed ceuse of daath (Itam 23a) (Type, Print) 30. Name and addrass of rikumalai,

Hospital:

1 Inpatient

28a. Data of Injury (Month, Day Year)

31. Date filad (Month, Dev. OCT 1 2 1999

25. Was case rafarred to medical axaminar?

1 Yas 2 No

27. Manner of Death 1 DNaturel

2 Accidant

3 ☐ Suicida

29a. Certifier

4 Homicida

(Check only

32. Registrar's Signatura

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Division of Vital

State Registrar **DHMH 16 Rev 6/95**

6 ☐ Could not be

00.1

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

ORIGINAL

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

medical Officer

32. Registrar's Signeture

1 ☐ Yes 2 ☐ No

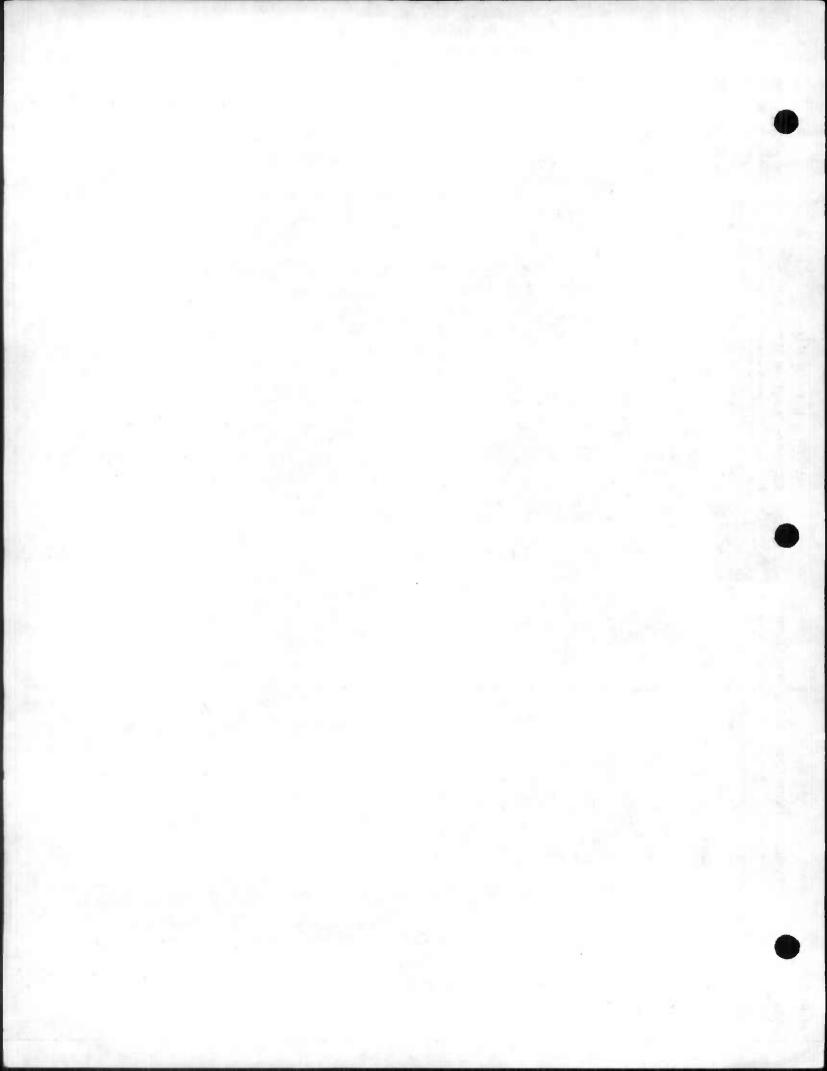
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Or. Prosper Sanchez, Franklin Square Hospital Center, 9000 Franklin Square Orive, Baltimore, Maryland 21337

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06:15 MARIAN MAE WEISINGER 10 40 Facility Name (If not institution, give street and number) Gichrest Center For Hospice Care 4b. City, Town, or Location of Death 4c. County of Death Gilchred Center BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 08-19-7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 F Months Hours 215-14-0472 Usuel Residence of Decedent 8 MARYLAND 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits BALTIMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Wes Decedent Ever in U.S. Armed Forces? 1 | Yes 2) ONo If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ECRETARY 18. Mother's Name 2 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Surname) WEISINGER JOHN TRIMES e. Zip Code) EllicottCity MD.21043 20b Place of Dispos 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removef from State CREMATORY INC 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOME 328 SULPHUE SPRING Rd ARBUTUS MD 2122 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset and Death Immediate Cause (Finel -010-7 months ancer disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): Due to (or as a consequence of) Pert ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hassic - Inget. 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

Examiner October 10, 19 signed by the atte Records, Weisinger Division of Vital al or Attending Physicien: T s star death. I Director: Atter this certifical To the Hospital within 24 hours a To the Funerel D

Physician

/Medical

Examiner

Funeral

Director

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Pagas 1 and 2 should be 1 nent of Haalth and Mental I int: if item 27 Is merked of

permit. Page Department of Important: If any Injury or

Physician /Medical

Maryland

Baltimore,

Funeral Director

Completed by

8

Physician/Medical

Completed by

8

edical Certification: To

3 ☐ Suicide

29e. Certifier (Check only one)

4 Homicide

funaral director,

complately filled in by tha

State Registrar

RAYMOND W. WILSON 31. Date filed (Month, Day, Year) OCT 12 1999

29b. Signature and little of certifier

6 Could not be

m.D 6565 32. Registrar's Signature

30. Name end eddress of person who completed cause of death (ftem 23a) (Type, Print)

MO

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

N. Chalo A.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

P41476

Suite 416 Baltimone

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10.10.1999

29d. Date signed (Month, Day, Year)

21204

ALC: CARACI SHANDAN AND ENGLISHED STANDARD OF THE COURT OF THE STANDARD OF Chile santo de mai filosofi cultura de manto de la come. Brest caración de manto de RELECTROMESTA DE CARACIO A CARACIO DE CONTRA LA CONTRA DE CONT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month OCTOBER 9, 1999 MARY EILEEN Z 4a Facility Nema (If not institution, give street and number) 1:20 PM 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year ff Under 24 Hrs. 5. Social Security Number 1□M 2×F 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Hours Deys 216-20-3225 Usual Rasidence of Decedant MARYLAND 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5523 ENUE NITED Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Race - American I Black, Whita, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 12. 1 Never Married 2 Merried 1 □ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) College (1-4or 5+) U.S. CUSTONS 12 IQUIDATOR 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HUGUST 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) KEVIN C ARSON SALTIMORE Mo. 21228 20c. Location - City or Town, State RLVD. 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20a. Mathod of Disposition Data 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) 22. Name and Address of Facility AMBROSE FUNERAL HOME 21. Signature of Funerel Service Licensee 23a. Part1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line thet caused the cleat. Do not anter the mode of dying, such as cardiac or raspiratory arrest, Approximata Interval Between Onset and Death Immediata Cause (Final disease or condition resulting in deeth) 1 MINUTE

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or lierns 23s or 28s-f show the Medical Examiner must be notified at

al Hygiene.

permit. Pages 1 and 2 should be till.
Department of Health and Mental Hy
Important: If Item 27 is mented oth
any injury or other traumatic even

Saltimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

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Funeral

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Completed

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Examiner

attending physician and for usa as the burial-transit by Completed has Be 2 funeral After To the Funeral Director: Aft
To the Funeral Director: Aft

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical that initieted events resulting in death) Last

CARDIAC ARREST

Due to (or es a consequence of)

MULTI-SYSTEM ORGAN FAILURE Due to (or as a consequence of):

SEPSIS

Due to (or es e consequence of):

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Pert II. Other algriffcant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

24 HOURS

48 HOURS

1 Yes

2) No 1 Yes

25. Wes case refarred to medical examiner? 1□ Yes 2 No 27. Menner of Deeth

5 Pending invastigation 6 Could not be datarmined

Inpatient 28a. Dete of fnjury (Month, Dey Year)

28b. Time of

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Placa of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, Steta)

29a. Certifier (Check only onel

2 Accident

4 Homicida

3 Suicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and fly of govern

29c. License number

29d. Data ned (Month, Day, Year)

30. Name and address of person who completed causa of deeth (Item 23a) (Type, Print)

Hospitel:

M. D., 7505 OSLER DR., TOWSON, MARYLAND GARTH MCDONALD, 21204

State Registrar

31. Dete filed (Month, Day, Year)

QCT 12 1999

32. Registrar's Signature

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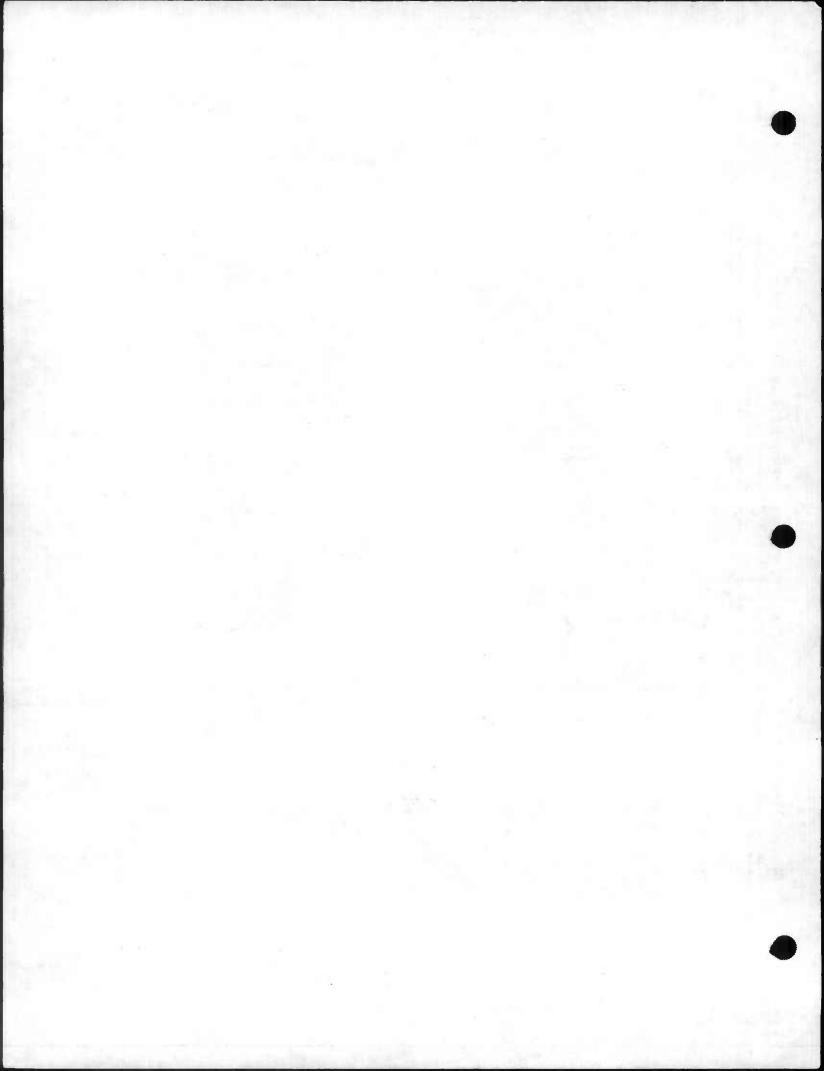
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State of Maryland / Department of Health and Mental Hygieneg 9 3 | 78 |

			Certificate of De	eath	Reg. No.	01701
D 1	1. Decedent's Neme (First, Middle, Last)			2. Date of I		3. Time of Death
Physician /Medical	Bernio	ce	Anton		mber 3	1999 12:24 AM
Examiner	4e Facility Neme (If not institution, give s	treet and number)		City, Town, or Location of De	ath 4c. County of	of Death
	Frederick Memor			Frederick		derick
Funeral Director	124-24-7872	7. Age (In yrs. last bi			Birth (Day, Year) 12, 1910	Birthplace (State or Foreign Country) Poland
2	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Location			10d. Inside City Limits
e Maryli Sert sho diffed at	Florida Broward		ut Creek			1 Yes 2 No
death with the Maryland ors 23s or 28s-f show crast be notified at neral Director	10e. Street end Number 2501 Antigua Terra	ace	10f. Zip Code 33066	6	10g. Citizen of W United	hat Country? States
5 2 E	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		nnic Origin? (Specify Yes or I Mexican, Puerto Rican, etc.) Specify:	No- 14. Race Black Specify:	- American Indian, c, White, etc. White
5-0 72 ho 72 ho methur fical.	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during	n na most al workina	16b. Kind of But	siness/Industry
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Merkal Hygiene. T is marked other than "natural", or traumatic event, the Medical Exams To Be Completed by F	Elementery/Secondery (0-12)	College (1-4or 5+)	Bookkeeper	ng most or morning	Accoun	nting
ind be filed dother overit, I	17. Father's Neme (First, Middle, Last)		-	. Mother's Name (First, Midd		
ylan Mental Ment	Abraham Skripsky			Rose Biletsk	у	
A STATE OF THE PERSON OF THE P	19e. Informent's Neme/Reletionship (Typ.	pe, Print) 19	b. Mailing Address (Street and			State, Zip Code)
	Linda Kincaid, da	aughter	5917 Jefferson	n Blvd. Fred	erick, Ma	ryland 21703
O - 7 5 5	20e. Method of Disposition	20b. Place of	of Disposition (Name of ary, crematory or other place)	Date	20c. Location - 0	City or Town, State
Pages sent of iny or o	Buriel 2 Cremetion 3 Re 4 Donetion 5 Other (Specify)	emover from State	on Cemetery	9/5/99	Oneens.	New York
afti porter y inju	21. Signature of Funeral Service Doense			Facility Stauffer		
m salas	TO PO	XL				Maryland 21702
	28a. Pagt. Enter the diseaser or complic shock, or heart failure. List only one	ations that comed the death. Do				Approximete Interval Between
Physician /Medical Examiner Examiner Examiner	Immediate Cause (Final disease or condition resulting in death) e.	Otherote Due to (or as a	lecotre Co	indervase	Deseo	Onset end Deeth 2 Years
(68760, rifficate be executed ng physician end e es the burlei-fransit Medical Examin	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	13000	consequence of):			
N Sing	that initiated events resulting in death) Lest	Due to (or es a	consequence of):			
he deeth y the etter ched for inysicial	Pert II. Other significant conditions cont	ributing to death but not resulting i	in the underlying cause given in	n Part I. 23b. Di	d tobacco use con	tribute to the cause of death?
S, P.O. Boy set that the deeth or igned by the ettend be detached for us by Physician/	algheimen			16	Yes 2 No	3 Probably 4 Unknown
v require been s should	Hyponotema			24a. Wi	as an autopsy rformed?	24b. Were autopsy findings available prior to completion of cause of death?
f Vital Repeted in the law relation. The law director, page 2 of the Comp	00			10	Yes 20 No	1 ☐ Yes 2 ☐ No
/Ita	25. Was case referred to medical		26	5. Place of Death (Check only		
of Vita Physician: this certific ral director,	examiner? 1 Yes 2 No	ospital: Inpatient 2 ER/O	utpatient 3 DOA Other:	4 Nursing Home 5 ☐ Re	sidence 6 Othe	r (Specify)
ding Ph After th funeral	27. Manner of Death 1∠Naturel 5 Pending		Time of 28c. Injury at Work?	28d. Describ	e how injury occurre	ed .
Vision Attending In death. Detor: After By the fune	2 Accident investigation	process, cas,		2 No		
C PART I	3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - At home, to building, etc. (Specify)	arm, street, factory, office		(Street and Numberown, State)	er or Rural Route Number,
To the Hospital Within 24 hours To the Funeral completely filled Medical C		cian: To the best of my knowledger: On the basis of examination are end manner steted.				
within To the comple	29b. Signeture and title of certifier		29c. License nu	imber	29d. Dete signed	(Month, Day, Year)
	· Aws		D20	516	SEPT	3 1999
	30. Name and address of person who con	npleted cause of death (Item 23a)	(Type, Print) NE FRED MP	21702		
State	31. Dete filed (Month, Day, Year)	32. Registrus Signature	- 4 1		-	

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** September 11, 1999 5:22 PM Athey Maxine Lillian /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
Sept. 10, 1916 West Virginia Birthplace (State or Foreign Country) **Funeral** 1□ M 2Q-F Hours 220-28-8780 83 Director Usual Residence of Dacedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland Frederick Point of Rocks 1 Yes 2 No Director 280-1 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3708 Commerce Street 21777 U.S.A. Nerra 23a Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 72 hours after 1 Nevar Marriad 2 Married b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and the filed within 72 and Mental Hygiene.

In marked other than "name unamic evene." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if Nem 27 is marked other
any injury or other trauments event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Edgar 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. James M. Costas, son 49 York Street, Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory, Sept. 16, 1999 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Frederick, Md. 21701

Approximately 1. Frederick, Md. 21701

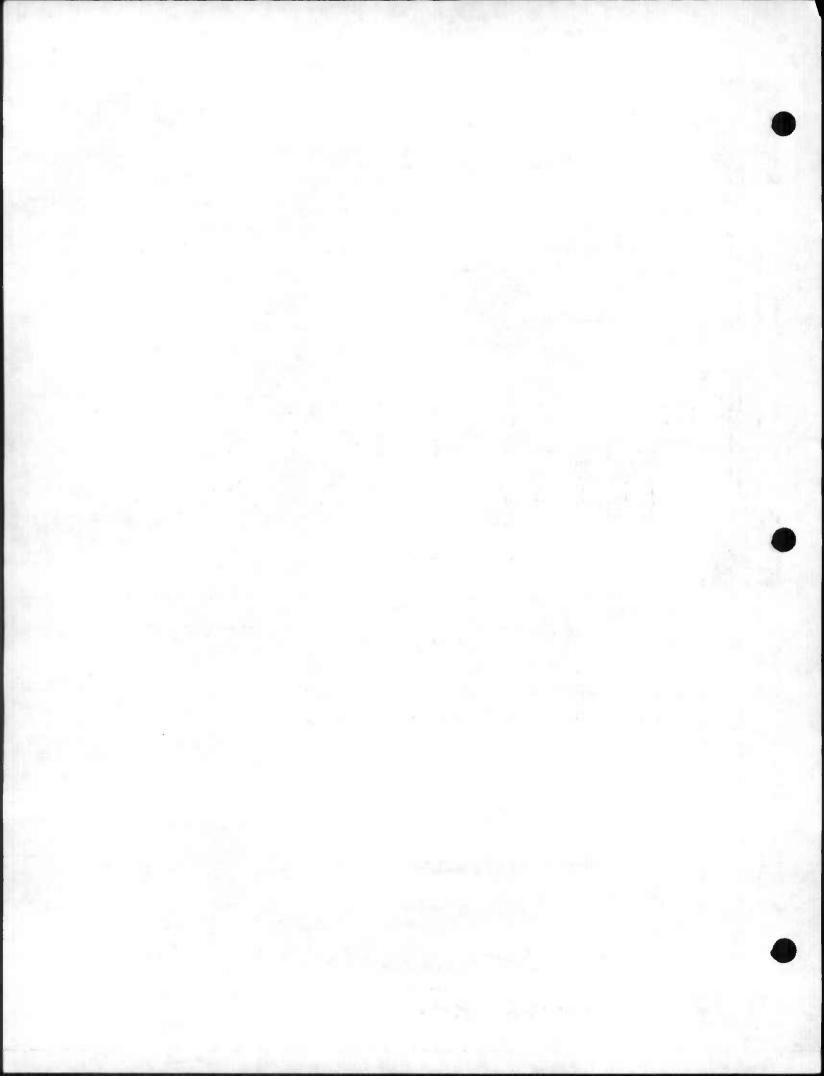
Approximately 1. Frederick, Md. 21701

Approximately 1. Frederick, Md. 21701 Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Aullisystem organ disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sepsis The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Anterior orters LUMPUNICALIM Physician/Medical the Dua to (or as a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No ubstructure of Vital Records. been signed should be d þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral 27. Manner of Death 12 Natural 2 Accident 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours a Hospital 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/29 00054619 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Thomas Johnson 6

Registrar DHMH 16 Rev 6/95

State

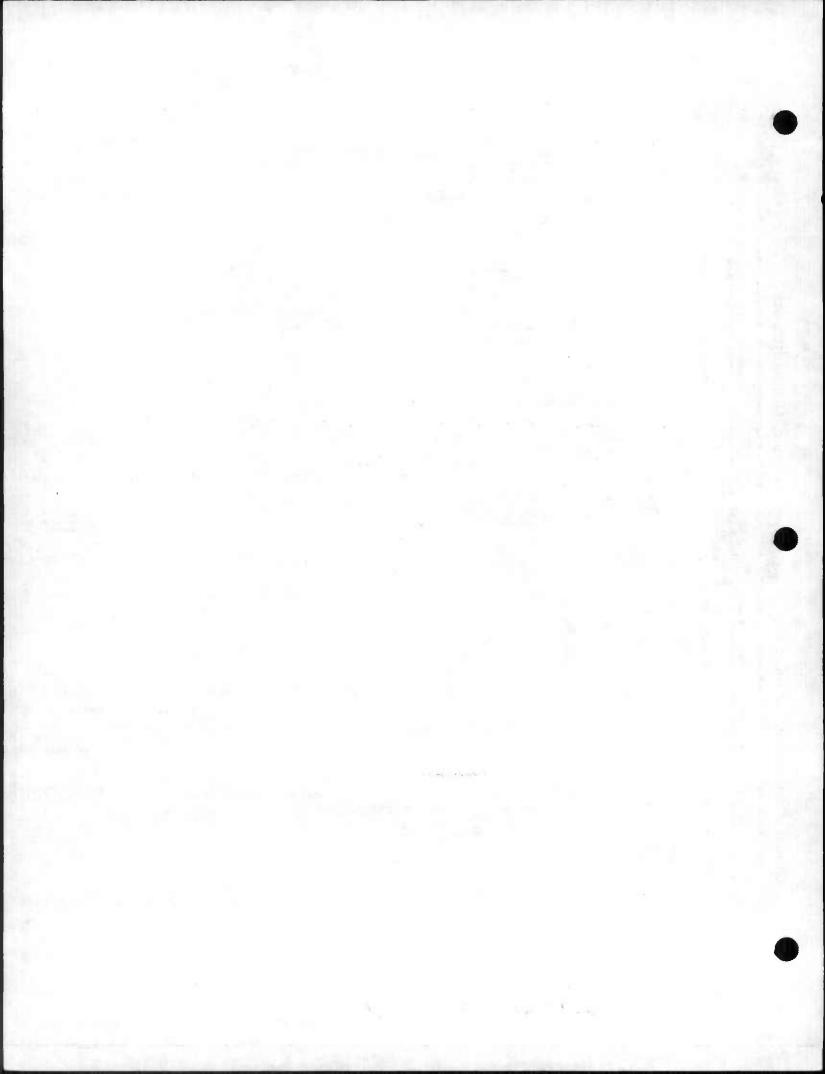
1 3 1999 Registrar Signatura



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State of Maryland / Department of Health and Mental Hygiene o

			01010 01 1110	C	ertificate	e of Dea		F	Reg. No.	3	1/8	3
	5	1. Decedent's Nama (First, Middle, L	ast)					2. Date of Dea Month		Year	3. Tima of	Death
	Physician /Medical	Margie Elaine	Weedon Am	bush				Septemb	er 26, 1		9:05	PM
	Examiner	4a Facility Name (If not institution, g				4b. City	, Town, or Lo	cation of Death	4c. County			
		Homewood Retires	ment Center			Fr	ederic	ck	Fred	terick	1	
	Funeral		Sex 7. Age	(In yrs. last birthde	y) If Under Months	1 Yaar If Un Days Hou	der 24 Hrs.	8. Data of Birth (Month, Day	1		ace (State o	or Foreign
	Director	219-05-5057 Usual Residence of Decedent	1□ M 20X(F	5 Yrs	WOULTS	Days	i viiit.	(Month, Day	, , , ,	Maryl	and	
	M M	10s. Stata 10b. County		10c. City, Town or	Location					100	d. Inside C	ity Limits
	death with the Marylar ms 23s or 28s-f show crount be notified at nerel Director	Maryland Freder	ick	Dicker	son						1 🗆 Yes	2 No
	or 28a-f	10e. Street and Number			10f. Zip	Code			10g. Citizen of V	Vhat Countr	ry?	
	MAN OF THE PARTY O	6740 Ed Sears R	oad			20842	2	1	Inited S	States	,	
		11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U,S. 1	3. Was Deced	ent of Hispanic	Origin? (Species Puedo	ecify Yas or No- Rican, atc.)	14, Rac	e - America		
Maryland 21215-0020	72 hours after natural, or its fical Examina sted by Fu	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced			1 Yas 2			riioaii, ato.,	Specify	20		
20	2 ho	15. Decedent's	Education	16a. De	cedent's Usua	l Occupation			16b. Kind of B	usinass/Indu	ustry	
215	ed within 72 ho ygiene. wr than "naturn t, the Medical. Completed	(Specify only highest g	rade completed) College (1-4or 5	+) (G	va kind of wor . DO NOT us	k done during i e retired)	most of work	ing				
2	of with	5			mestic				self			
Pu	d office the sent and	17. Father's Nama (First, Middle, Las	st)			18. M	other's Name	a (First, Middle,	Meiden Suman	ia)		
yla	Went Went To I	Lewis Weedon					Bert	ha Boi	vins			
ar	pund and a	19a. Informant's Name/Ralationship	(Type, Print)	19b. M	iling Addrass	(Street and Nu	imber or Run	al Routa Numbe	r, City or Town,	Stata, Zip (Code)	
	and and and and and and and and and and	Margaret Ambush	Jackson/dau	ighter 21	7 E. 4	th St.,	Fred	erick, 1		-		
ore	t off Ten	20a. Mathod of Disposition 1 Di Burial 2 Cremation 3	Dameuel from State	20b. Place of Discemetary, of	position (Nan remetory or of	ne of thar place)		Data	20c. Location -	City or Tow	m, Stata	
Ĕ	Pages nant of any or o	4 Donation 5 Other (Spec		St. Pau	e Cemer	tery	19	/30/99	Dickers	on, MI)	
altimore	P Ports	21. Signature of Funeral Servicertion	90000	1 1	22. Nama and	d Address of Fa	acility Stat	ubber Fi	ineral t	tomes,	P.A.	
œ	SSEES	1/201	SEM	K	1621 0	nassuma	town P	ike, Fro	donich	MD 5	1702	
		23a. Part1. Enter the disease, or co- shock, or heart feilure. List on	mplications that caused								Approximat	la
8	Physician	snock, or neart tellure. List on	ry one cause on each tir	е.							Onset and	Death
A	/Medical	Immediata Cause (Final diseasa or condition	ta	mant	~ (2000	1				2 ~	- 10
9	Examiner	resulting in death)	a	Due to (or es e con		ONCU	2				1001	THE
	ě			000 10 (01 00 0 001								
	ifficate be associted giphysician and as the burial-transit edical Examiner	Sequentially list conditions	b	Due to (or es a con	sequence of):							
ó	E PE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								1		
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_	E 04 -	leading in death cast								1		
Box	at the death certification of by the attending letached for use as Physician/Me		d							1		
	deat of for	Part II. Other significant conditions	contributing to death bu	it not resulting in th	underlying ca	ausa given in P	art I.	23b. Dld t	obacco use co	ntribute to	the cause	of death?
P.0	ras that the designed by the a libe detached if by Physic							101	08 2 No	3 Probe	ably 4	Unknown
ŝ	gned be de by F								/			
Records,	law requires that the death certain sa been signed by the attending 2 should be detached for use about by Physician/W								an autopsy med?	24b. War	ra eutopsy ilable prior	lindings to
00	The law requir										npletion of death?	cause
Œ	8 4 6 F							10 Y	as 2 No	10	Yas 2	No No
	certificate rector, page	25. Was case referred to medical				26. P	Place of Deat	h (Check only o	na)			
>		axaminer? 1 Yes 2 No	Hospital:	nt 2 ER/Outpa	ient 3 DO	A Other: 45	Nursing Ho	ma 5 Rasid	lance 6 Oth	ar (Specify))	
0	er this neral d	27. Manner of Death	28a. Data of Injur (Month, Day	y 28b. Time		8c. Injury at Work?	4	28d. Describe h				
0	atio	1 Natural 5 Pending 2 Accident investigati		Year) Injur	М	1 Yas	2 □ No					
Division	all or Attending P rs after death. all Director: After t led in by the funer: Certification:	3 ☐ Suicide 6 ☐ Could not detarmine	d 289. Place of Inju	iry - Al homa, farm,	street, lactory	, office		281. Location (S City or Tow	Street and Numl	er or Rural	Routa Nur	nber,
ā	Dan E	4 Homode	building, etc	. (Specify)				Ony or You	iri, Oleley			
	To the Hospital or Attending Phwihin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral medical Certification:		hysician: To the best of	examination and/or								s)
	Med Med	29b. Signature and title of certifier	and manner sta		290	. License numb	ber		29d. Date signe	d (Month, E	Day, Year)	
	F 3 F 8	1 0	Howell	6.0					- 1	100		
		1				W71	007	0	1101	177		
		30. Nama and address of pirnon who	o completed cause of de		e, Print)	25056	TON	5 mc	21	701		
	0	31. Date liled (Month, Day, Year)		Signatura	TR	CUER	TIME	1194	/ XI	100		
	State	SED 2	7 1999	3ener	14	1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 2. Dete of Deeth Deyle 1999
September 16 1999 1215 **Physician** Earl Alloutt Senior obert /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner 15001 Sugarland Road Poolesville Montgomery If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dev. Year) 5. Sociel Security Number 6 Sex 9. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F 76 Yrs. Director 579-22-1809 Nov 10 1922 Maryland Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a Stete 10d Inside City Limits 10b. County must be notified at MD Montgomery 1 ☐ Yes 2 No Poolesville Director 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street and Number filed within 72 hours after deeth with 15001 Sugarland Road U.S.A. 14. Race - American Indien, Bleck, White, etc. Funeral 20837 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) r than "naturel", or items the Medical Examiner ma 1X Yes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 X No Specify: white Specify: by 3 Widowed 4 Divorced Yeer or Detes: WW11 "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) Bus Driver / . Pages 1 end 2 should be filed wi tmant of Health and Mental Hygien tant: If item 27 is marked other the jury or other traumatic event, the farmer Farmer 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Clarence Leonard Allnutt. Sr Laura Howard 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Ila Hubble Allnutt/wife 15001 Sugarland Rd. Poolesville, MD 20837 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ⊠ Buriel 2 □ Cremetion 3 □ Removel from Stete permit. Page Department of Important: If any injury or once. Boyds Presbyterterian 9/21 4 ☐ Donetlon 5 ☐ Other (Specify) Boyds, MD 21. Signeture of Funerel Service Licensee 22. Neme end Address of Fecility Hilton Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erresponds, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** shageal eanler /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): and Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) 88 esn 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificeta Hospital or Attanding Physician: Be 25. Was cese referred to medical exeminer? 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 12 Residence 6 Other (Specify) 1 Yes 28 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. fnjury et Work? Aftar 1 Neturel 5 Pending investigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completaly filled in by the fun 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier Koesari

State Registrar

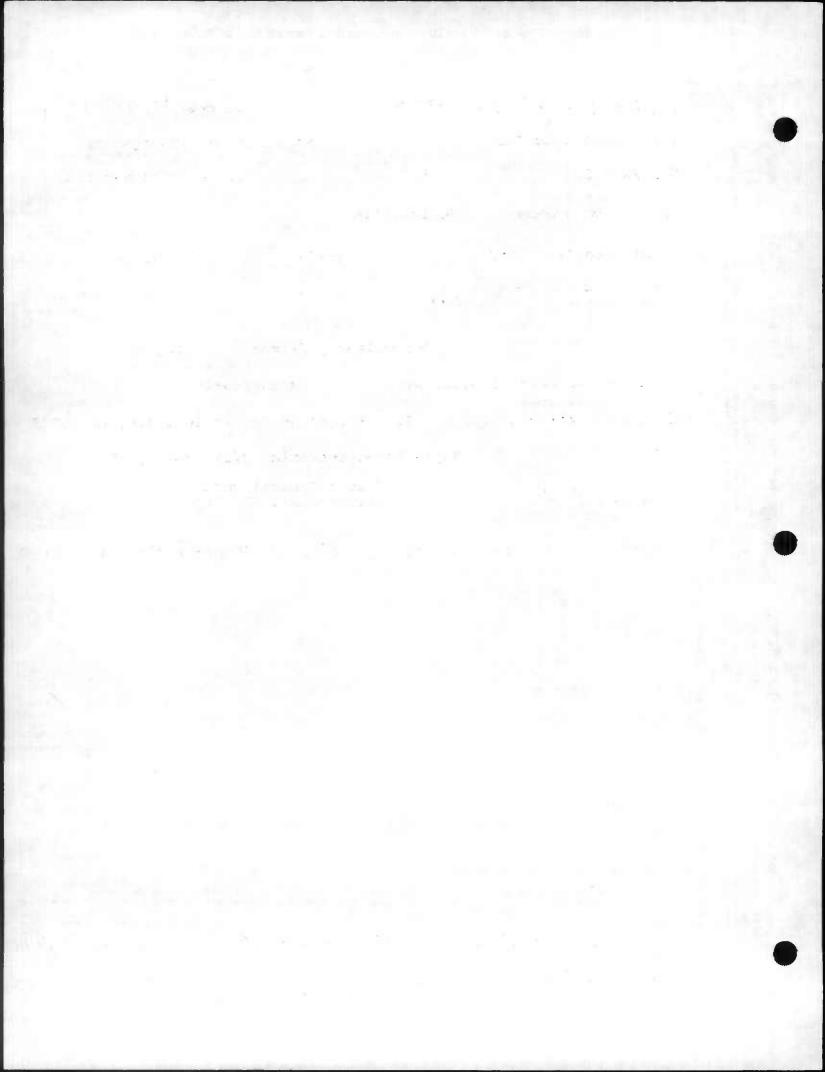
Labkhand 31. Dete filed (Month, Day, Year)

KOSSAVI, M.D 32. Registrer's Signature 34 person

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

1 North Frederick Avenue Egithersburg, Maryland 20877

501



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey 540tambar 15,1999 Ammerman Earl 10:05 am 4a Facility Neme (If not institution, give stre 4c. County of Deet! 4b. City, Town, or Location of Death Hopkins Baltimore Baltimora par If Under 24 Hrs. 8: Johns If Under Months 1003 CITY 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex Birthplace (State of Foreign Country) Days Hours 1 M M 2 □ F 182-20-3732 1925 Pennsylvania Usual Residence of Decedent 10b County 10c City Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6955 Regents Court, Apt 108 21703 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 (1) Yes 2 No If Yes, Give Yeer or Dates: 1943-46 1 ☐ Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Toner Ammerman Emma Darling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Linda Ammerman, wife 6955 Regents Court, Apt. 108, Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata Resthaven Memorial Gardens 9/18/99 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Fecility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth

Physician /Medical Examiner

Department of Important: If any Injury or DOCE.

Physician

/Medical

Examiner

10a. Stete

Funeral

Director

"natural", or items 23s or 28s-f show edical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.

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Baitlmore, Maryland 21215-0020

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

Be

Medical Certification: To

the Maryland

physician and the burial-transit

signed by the all

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After

24 hours after death.

To the To the To the F

Hospital

filled in by

completely

or Attanding Physician: The law requires that the deeth certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Immediate Cause (Final disease or condition resulting in deeth) Oneumonia Due to (or es a consequence of): oration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. nerve palsen

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

- 1		ontribute to the cause of death?
	1 ☐ Yes 2 No	3 Probably 4 Unknown
	24a. Was en autopsy performed?	24b. Were autopsy lindings available prior to completion of cause of deeth?
	1 ☐ Yes 2 No	1 ☐ Yes 2 No
h (C	Check only one)	
me	5 ☐ Residence 8 ☐Ot	her (Specify)
280	d. Describe how injury occu	rred

25. Was case referrexaminer?	
27. Manner of Deeth	
1 Natural 2 Accident	5 Pending investig

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 28c. Injury et Work? 1 Yes 2 No

26. Place of Deeth (C

29a. Certifier (Check only one)

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

MD

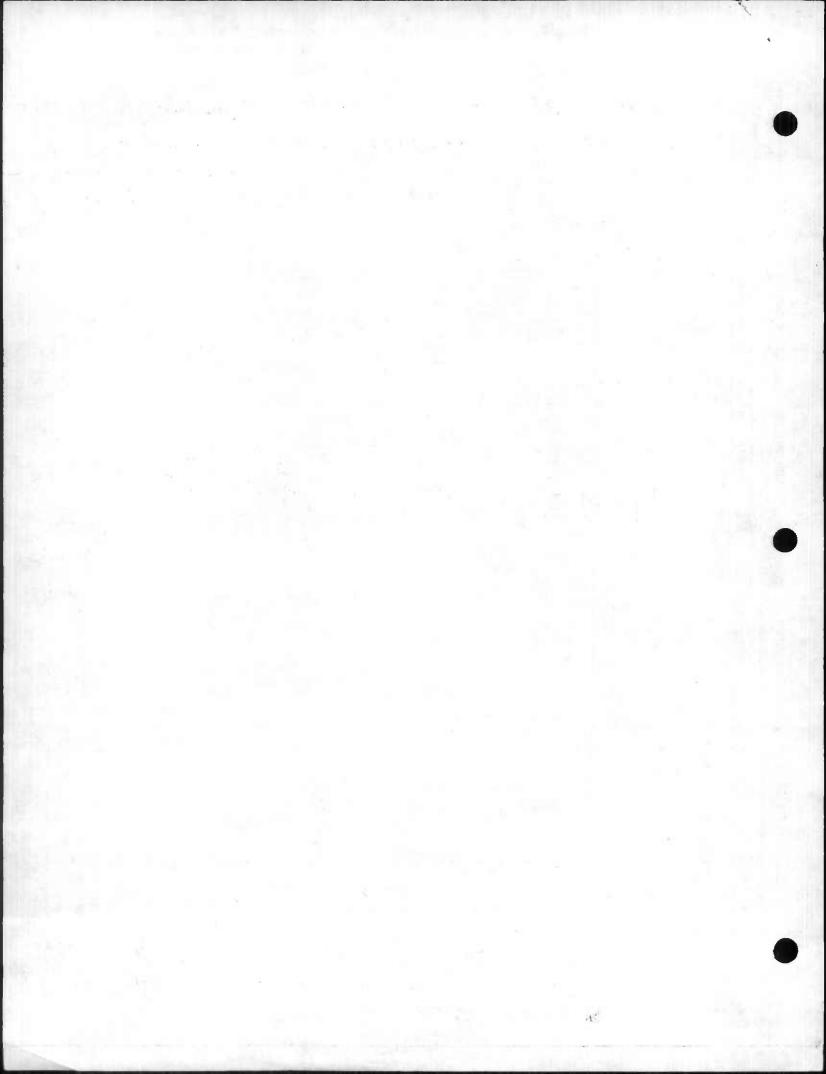
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30. Nema end address of person who completed cause of death (Item 23a) (Type, Print)

Connie State Registrar

Lynn 600 North Chen 32. Registrar' Signatu 31. Date filed (Month, Day, Year) 1999

, Baltimore, Maryland 21287 Wolfe Street



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Year **Physician** Lemuel Martin Breckenridge Sept. 1999 8:40 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4745 Mussetter Road Ijamsville Frederick 8. Data of Birth (Month, Day, Year) 6. Sax 1 M 2 □ F 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours Yrs 83 213-16-0251 Director June 8, 1916 Maryland Usual Rasidance of Decedant the Menyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examiner mant be notified at 1 Yas 2 No Director Maryland Frederick Ijamsville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4745 Mussetter Road 21754 USA filed within 72 hours after death Hygiena. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1∑ Yas 2 ☐ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Orlgin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American indian, Black, Whita, atc. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2) No Specify: Specify þ 3 Widowed 4 □ Divorced White Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Rigger Shipbuilding. 18 Mother's Name (First, Middle, Maidan 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem Z7 is marked oth any liqury or other traumatic event page. Roger Delaney Breckenridge Bessie Elizabeth White 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, State, Zip Code) Shelvie Rice, daughter 4745 Mussetter Road, Ijamsville, MD 21754 20a. Method of Disposition

1 Disposition 3 Ramoval from State 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 4 □ Donation 5 □ Othar (Specify) Olivet Cemetery 9/3/99 Frederick, Maryland 22. Nama and Addrass of Facility Keeney and Basford Funeral Home M00999 106 East Church Street, Frederick, MD 21701

23a. Part1. Enter the disease Yor compositions that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, and interval Berth Church Street, Frederick, MD 21701

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Approximate I Approximata Interval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) /Medical 3 yrs. 4 mo. Lung Cancer Examiner Dua to (or as a consequence of) Physician/Medical Examiner ician end buriel-transit The law requires that the death certificate be axecuted Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that Initiated avents rasulting in daath) Last Dua to (or as a consequence of) Box 68760. ettending physician for use es the burie Dua to (or as a consequence of) ed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 TyYes 2 No 3 Probably 4 Unknown Coronary Artery Disease Division of Vital Records, by 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy parformad? Completed been certificata has 1 Yas 2 No Physician: 25. Was casa rafarrad to madical axaminar? Be 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 ARasidance 6 Othar (Specify) 10 To the Hospital or Attending Physical by the Hospital of Hours after death.

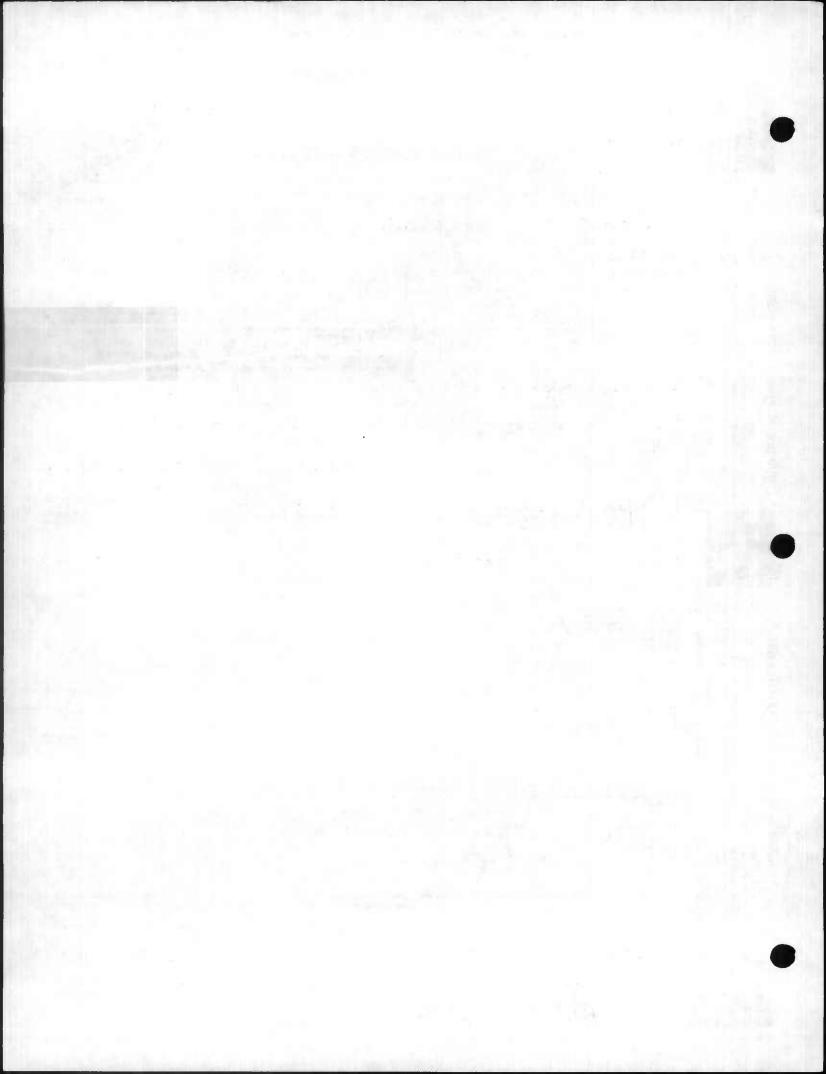
To the Funeral Director: After this completely filled in by the funeral directors. 27. Mannar of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accidant 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 6 Could not be datarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 | Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar edical (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar many litterulle mo D46075 September 2, 1999

170 Thomas Johnson Dr., Frederick, MD 21702

State Registrar 30. Name and address of person who complated cause of daath (Itam 23a) (Type, Print)

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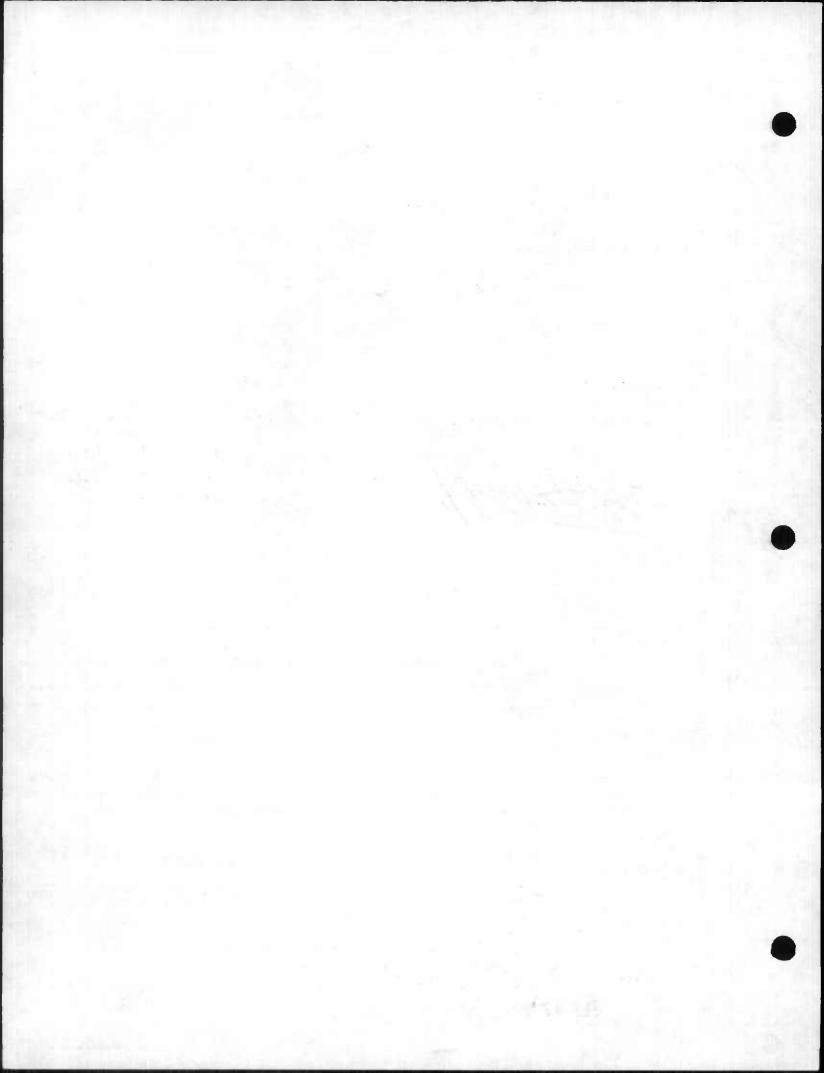
Mary P. Howell, MD, 31. Date filad (Month, Day, Year) SEP 03 19



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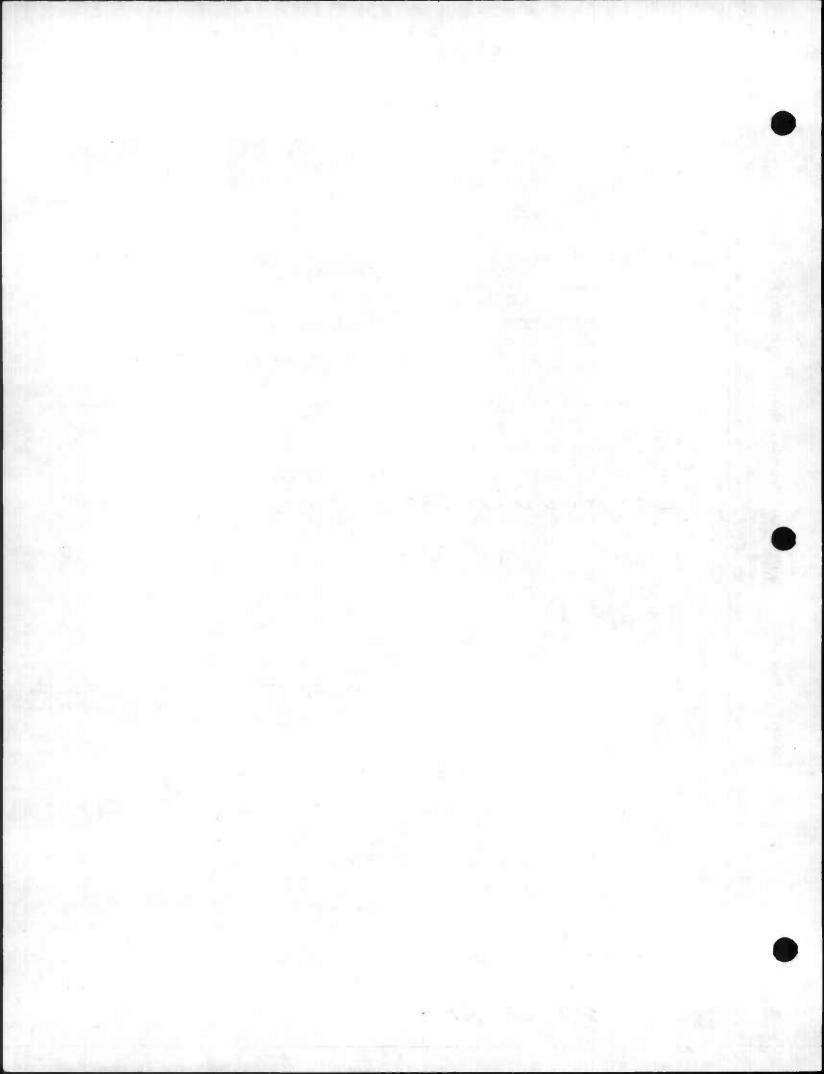
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day1999 Year Physician SEPT. 0200 4, RUTH VICKERS BROWN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) Feb. 9, 1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Days 1□ M 2以F 92 Mary land Yrs. 219-36-6518 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Medical Examiner must be notified at Md. Frederick Frederick 1 Yes 2 No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 21702 990 Waterford Drive Norms 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Heelih end Mentel Hygiene. I my contant: If lem 27 is marked other than "natural", or flee any injury or other traumatic event 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Education Elem. School Teacher College 4 years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grace Williams Raymond Vickers P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Rock Creek Drive Frederick, Md. (Son) Mr. Ridgely T. Brown, Jr. 20b. Piace of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stele 9-8-99 Pompano Beach, FL. Forest Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fung ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701 Approximete Interval Between Onset and Death with. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) bcurd Examiner Due to (or es a consequence of): Examiner repsi ettending physician and for use as the burial-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last iquence of): P.O. Box 68760. Physician/Medicai been signed by the should be detached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1XX Inpatient edical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Netural 2 Accident ne Hospital or Attending in 24 hours after death. he Funeral Director: Aft pletely filled in by the fur 1 Yes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture WD 30. Name and address of completed cause of death (Item 23a) (Type, Print) person w 32. Registra S State 1999 Registrar



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	State of	Marylan		oartmer e <i>rtificat</i>			and N	Mental Hy	giene C	9	31789
1. Decedent's Neme (First, Middle	Last)							2. Dete of Dec		5.5 100	3. Time of Death
Garner	C. Ban	ber						Month Septemb	er 6. 1	Yeer	10:00 AM
te. Fecility Neme (If not institution,	give street and num	nber)				4b. City, To		ocation of Death		y of Death	10.00 AM
13612 Penn Shor						Mount	⊢ Λ - 1	*17		erick	
		7. Age (In yrs. i	ast birthda) If Unde	r 1 Year			8. Dete of Birt	h		
218-14-8619 Usuel Residence of Decedent	1 X M 2 □ F	80	Yrs.	Months	Deys	Hours	Min.	Oct. 17	, 1918	Mary	lece (State or Foreign try) Land
10e. State 10b. County		10c. City	, Town or I	_ocation						1	0d. Inside City Limits
Maryland Frede	rick	Mo	unt A	irv							1 ☐ Yes 2 No
10e. Street end Number				10f. Zip	Code				10g. Citizen of	Whet Coun	try?
13612 Penn Sho	p Road				217	71			U.S.A	Α.	
11. Maritel Stetus 1 □ Never Married 2 □ Marrie 3 🏹 Widowed 4 □ Divorced	Armed For	2 X No	S. 13	. Was Dece if Yes, spe 1 \(\text{Yes} \)			gin? (Sp n, Puerto	pecify Yes or No Ricen, etc.)	14. Ra Ble Specifi	ce - Americ ock, White, fy: Whi	etc.
15. Decedent' (Specify only highest	s Education		16e. Dec	edent's Usu	el Occup	pation	t of word	daa	16b. Kind of E	Business/ind	fustry
Elementery/Secondery (0-12)	College (1-	-4or 5+)		ainte		during mos d)	. 01 4011	an ig	House		
17. Fether's Neme (First, Middle, L	ast)			azmee	_	18. Mothe	r's Nem	e (First, Middle,			
James M. Bar	ber						Dell	la Watk	ins		
19a. Informent's Name/Relationsh	ip (Type, Print)		19b. Ma	ling Address	s (Street	and Number	er or Ru	ral Route Numbe	er, City or Town	, State, Zip	Code)
Shirley Ann Kar	ne - Niece	9	684	6 Dors	sey	Road,	E1	kridge,	Maryla	nd 21	075-6207
20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremetion 4 ☐ Doneyon 5 ☐ Other (Sp			matani or	oosition (Name of the organization) or the organization of the organization of the organization (Name of the organization) or the organization of	other pla	ce) list (Cem.	Dete 9/10/99	20c. Location Dama:		wn, Stete Maryland
21. Signeture of Funeral Service L	· Will	inne		22. Name er Dlin L 26401	nd Addre	oss of Facility Dleswo	rth	P.A., I	s, Mar	Home yland	20872-011
23a. Pert1. Enthr the disease, or o shock, or hard feilure. List o	only one cause on ea	ech line.	. Do not e	nter the mod	oe or ayı	ng, such as	cardiac	or respiretory er	rest,	1	Approximete Intervel Between Onset end Deeth
Immedlete Ceuse (Finel disease or condition resulting in deeth)	e. 6	care	- /	Muze	to	w	gen	who	net	or ,	minutes
g ·/	Ť.	Due to (or	es e cons	equence of):				0			
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying	b	Due to (or	es e cons	equence of):						1	

Physician /Medical Examiner

siclan end burial-transit

been signed by the ettending physician should be deteched for use as the buna

page 2

funeral director,

completely filled in by the

After this certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

þ

Completed

Be

P

Certification:

edicai

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiene. Improvement of Heelth and Mentel Hygiene. Improvement if them 27 is marked other than "netural", or items 28a or 28a-f ahow any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last

10e. State

	Due	to (or es e	conseque	rice or):	
_					
	Due	to (or es e	conseque	nce of):	

Due to (or es a consequence of):

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Wes an eutopsy performed?

24b. Were eutopsy findings eveilable prior to completion of cause of deeth?

1 Yes 2 No 28. Piece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25.	Wes case referre exeminer?	d to medical
	1 Yes 2□N	0
27.	Manner of Death	
	1 Naturel	5 Pending

2 Accident

3 Sulcide

28e. Dete of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of cerui

D26499

29c. License number

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

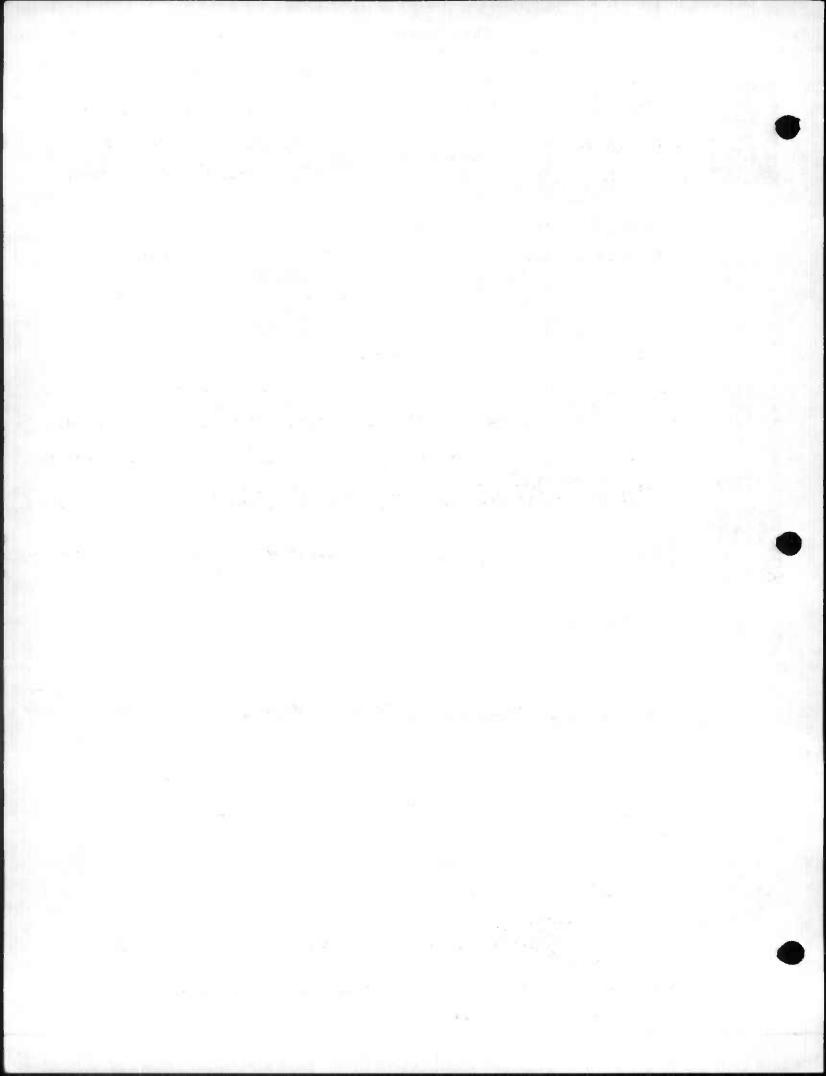
SEP 1 0 1999 >

Ronald E. Miller, M.D. 31. Dete filed (Month, Day, Year)

32. Registrer, Signeture

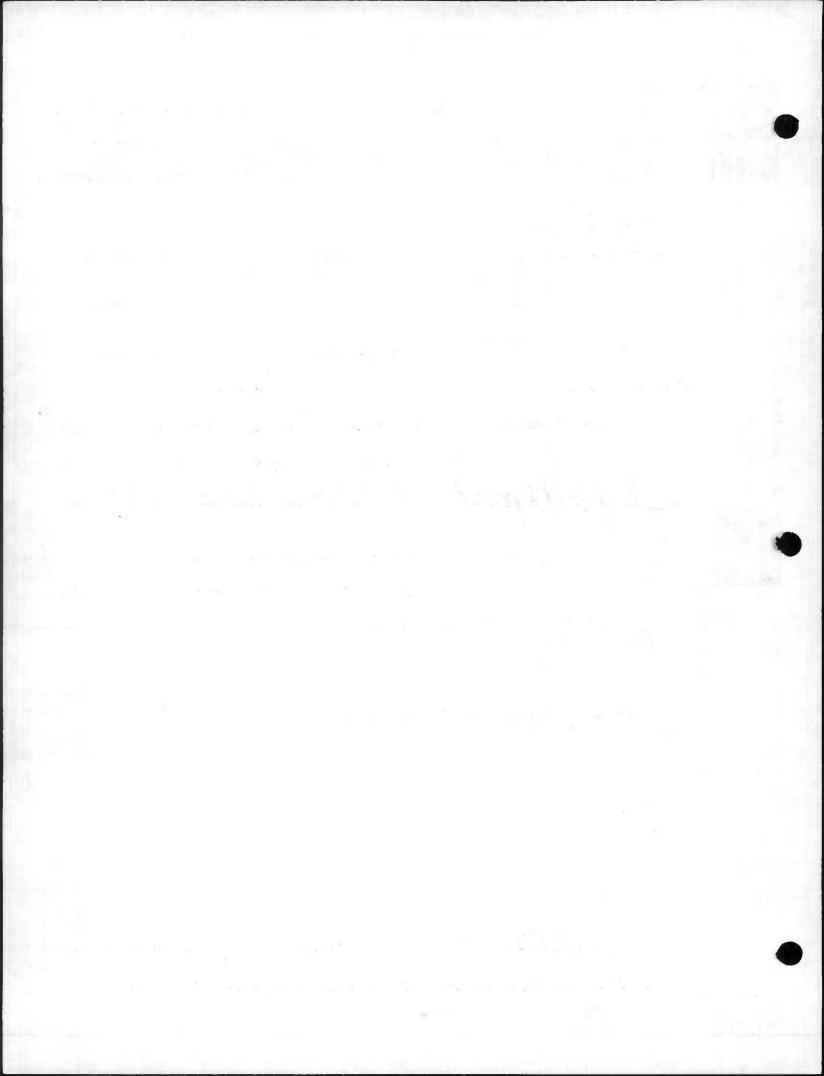
Culwell Drive, Mount Airy, Maryland 21771

State Registrar



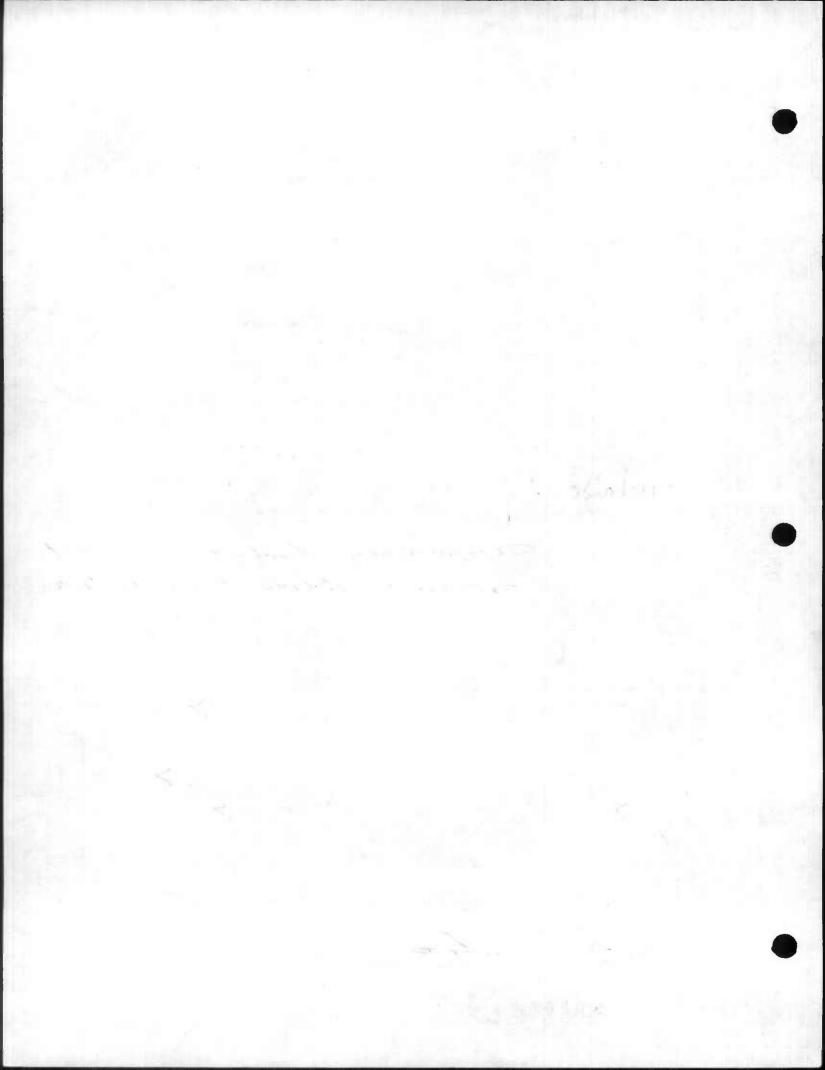
State of Maryland / Department of Health and Mental Hygiene 9

					Cer	tificate of	Death		Reg.	No.		
Dhuni	aiam.	1. Decedant's Name (First, Middla, Las.	t)					2. Data o		Day	Yaer	3. Tima of Death
Physi /Med			Doris V	. Barı	nett					10,		8:30pm
Exam		4e. Facility Name (If not institution, give	street and number)				4b. City, Town	n, or Location of I		4c. County		
		11104 Mountain Vie	ew Lane				Ijam	sville		Fre	deric	:k
Funera	1	5. Social Security Number 6. Se		(In yrs. last	birthday)	If Under 1 Year	If Under 24		of Birth			laca (State or Foraign
Directo	r	577-44-5935	□M 2⊠F	67	Yrs.	Months Days	Hours	Min. (Monti	3. 1			ington D.C
ъ.		Usuel Rasidance of Decedent										
ryler how		10a. Stata 10b. County		10c. City, To	own or Lo	cation					11	0d. Insida City Limits
e Me	Ş	Maryland Frederic	ck	Ijams	svill	.e						1 ☐ Yes 2KD No
F 28	- e	10e. Street end Number				10f. Zip Coda			10g.	Citizen of	What Coun	itry?
h wil	<u>a</u>	11104 Mountain Vie	ew Lane			2175	54		11	nited	Stat	-05
eep ge	Funeral Director	11. Maritai Status	12. Was Decedent E	evar in U,S.	13. V	Ves Decedent of I	Hispanic Orlgin	? (Specify Yas	r No-	14. Rac	e - Amaric	an Indien,
after at a		1 Never Merriad 2 Married	Armed Forcas? 1 ☐ Yas 2 ☒ N	lo	1	Yas, specify Cub		Puerto Hican, etc	.)		ck, White,	
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d 2 should be file th end Mentel Hy 7 Is merked other traumatic event	Be (17. Fathar's Nama (First, Middle, Last)					18. Mothar's	Nama (First, Mi	ddia, Maid	dan Suman	ne)	
should be nd Mentel marked o	To	Herbert Thompson					Rose	Matthews	5			
s me		19a. Informent's Name/Ralationship (T)	ype, Print)	1	9b. Mailin	g Addrass (Strae	t and Number	or Rural Routa N	umber, Ci	ty or Town,	Stata, Zip	Code) 21754
		Johnnie Baker/ Day	ughter			Mountai						
Department of Health moortant: If Item 27 any Injury or other the		20a. Mathod of Disposition		20b. Place	of Dispos	sition (Nama of natory or other pla		Data	20c	. Location -	- City or To	wn, Steta
permit. Pages Depertment of Important: If Its any Injury or or		1 ☑ Burlal 2 ☐ Cramation 3 ☐ F				Forest C	•	0/15	0	rzinaa	Mali	- Massal
nit. orta		21. Signature of Funeral Service Licens		Gulli	-	Nama end Addra		y 3/13	0	wrngs	MILI	s,Marylan
Deperminant International		1 h/1/2/1	knier	/	01	in L. Mo	leswor	th P. A.	Fun	eral	Home	
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		23a. Part1. Entar tha disease, or comp shock, or haart failura. List only o	na cau a on each lin	e.	o not ante	ir tria moda or dyi	ing, such as ca	rdiec or respired	ny errast,			Approximata Intarval Batween Onset end Deeth
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and and	Examiner	Sequantially list conditions, if eny, laading to Immadieta causa. Enter Underlying	1	Due to (or as	a consequ	uence of):	1					'
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ires the	by	/	1	,			·					
he law requires to hes been signed age 2 should be to	Completed								Was an eu performed		eve	ara autopsy findings Bilabla prior to
e law hes b	ğ							-		,	of c	mplation of causa daeth?
The la ate he	5								1 ☐ Yes	212 No	1 🗆	Yas 2□ No
Attending Physician: The receipt. sector: After this cartificate by the funerel director, pag	Be (25. Was casa rafarred to madical examinar?					26. Place of	Deeth (Check of	nly ona)			_
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er th		27. Manner of Death	28a. Data of Injury (Month, Day	y 28t	. Tima of	28c. Inju Wo	ry at			njury occur		
or Attending Physician: Tafer deeth. Director: After this certificat	atio	1 ☑ Natural 5 ☐ Panding 2 ☐ Accident invastigation	(Workin, Day	rear)	Injury		Yas 2 □ No					
Afte or de by th	을	3 ☐ Sulcida 6 ☐ Could not ba 4 ☐ Homlcida detarmined	28a. Placa of Injur		farm, stre	et, factory, office					er or Aura	l Routa Number,
s after	Certification:	4 I Homoda	building, atc.	. (Spacity)				City o	r Town, Si	are/		
spit hour ners y fills		29a. Cartifier 1 Certifying Phys	sician: To the best of	f my knowled	lge, daath	occurred et the ti	me, date end p	olaca, and dua to	the cause	e(s) end me	enner as st	ated.
To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Exami	ner: On the basis of end mannar stat	examinetion	end/or Inv	estigation, in my	opinion, daath	occurred at the t	me, date	and pleca,	and due to	tha ceusa(s)
To the	Σ	29b. Signature end title of	11.			29c. Licans	sa nu <i>m</i> ber		29d.	Data signe	d (Month, I	Day, Year)
		Mele	u	_		D2	6499		Se	enteml	ber 1	1, 1999
		30. Nama and addrass of person who co	omplated cause of de	ath (Itam 22	a) (Tuno E					- F = 0 iii		-, -,,,
		Ronald E. Miller,					n = A =	. M 4	a 1	0.1	771	
	ate	31. Data filed (Month, Day Year)	32. Registral	Cu IWe I	T DI:	ive, Mou		-	and	21	//1	
Si Regis	tate trar	SEP 1 3	1999 Registra	Bener	-	B. A	/					
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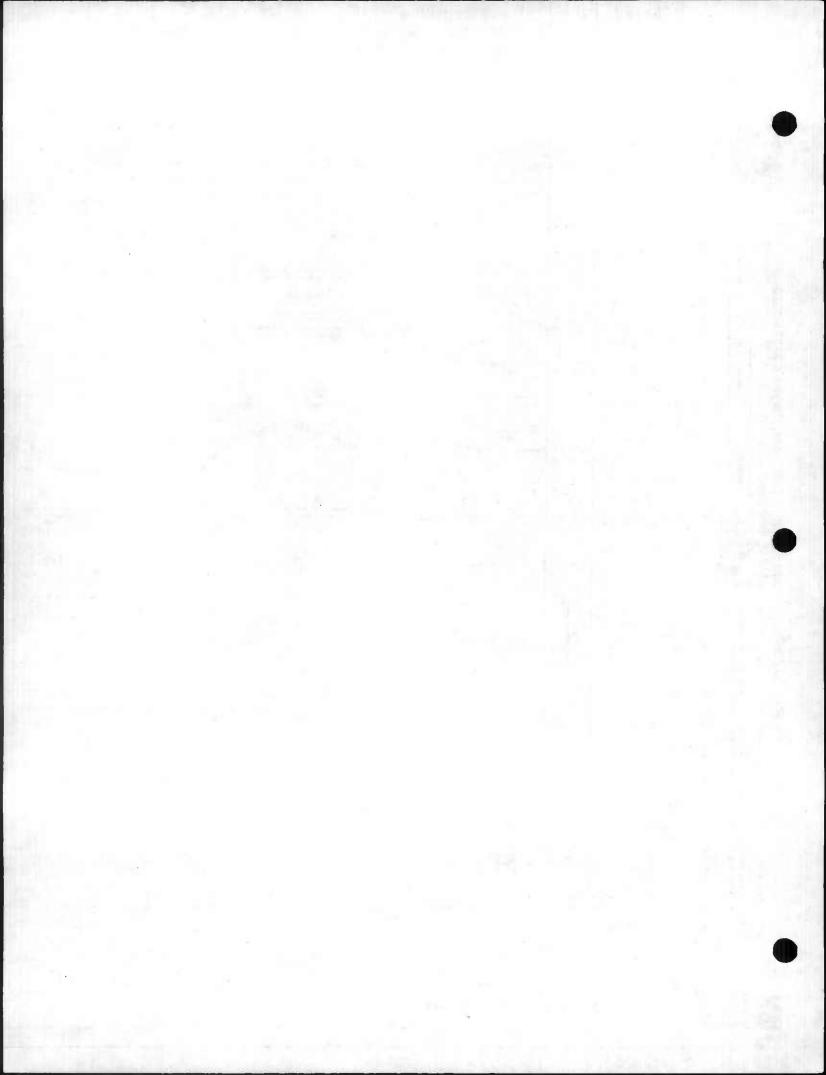
State of Maryland / Department of Health and Mental Hygiene 99 3 1 79 1

			Ce	rtifica	te of	Death		Reg.	No	J	1151
Dhuaisia	1. Decedent's Neme (First, Middle, La	est)					2. Dete d	1	Day	Year	3. Time of Death
Physicia: /Medica	KANNATH	Martin		В	ırdet	te	Septe	ember	17, 1	999	6:00 am
Examine	de Coelle, Nome Manting in the element	e street end number)				4b. City, Town	, or Location of I	Death	4c. County o	Death	
199	10318 Woodsbo	ro Pike					ersville	5	Fre	ederi	.ck
Funeral Director	215-38-6366	6ex 7. Age (In yrs. 57	last birthday Yrs.	Months	er 1 Year Days	If Under 24 Hours	Min. (Monti	of Birth Day, Yea	1941	9. Birthple Counti Mary	ace (Stete or Foreign ry) land
D	Usuel Residence of Decedent 10a. Stete 10b. County	10c. Ci	ty. Town or L	ocation						10	d. Inside City Limits
Sa-f aho	Maryland Freder		alkers	ville							1 □ Yes 2XX
th with the 23s or 2	109. Street and Number 10318 Woodsbor	co Pike		10f. Z	ip Code 217	93			Citizen of Wh		ry?
020 urs s	11. Meritel Stetus 1 X Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in L Armed Forces? 1 ☐ Yes ♣ Sto No If Yes, Give Yeer or Detes:	l,S. 13.	If Yes, sp	edent of Hecify Cubi	lispanic Origin an, Mexican, F Specify:	? (Specify Yes o Puerto Rican, etc	or No- .)	14. Reca Bleck,	, White, e	tc.
5-0 72 hx	15. Decedent's E (Specify only highest gr		16a. Dece	edent's Us	ual Occup	etion during most o	f working	16b.	Kind of Bus	iness/Indi	ustry
id 21215-0020 filed within 72 hours of Hygiene. Wher than "natural", or ont, the Medical Exam	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12) 8	College (1-4or 5+)		er Op		during most of d) OT			Towing	Bus	iness
X 27 B 15	17. Fether's Neme (First, Middle, Last)				18. Mother's	Name (First, M	ddle, Maid	len Sumeme)	
ylan ylan lould be i Mental marked o	Martin Le	eo Burdette				Rut	h		Summ	ers	
Mar d 2 sh th and 7 ie m traum	19e. Informent's Name/Reletionship Ms. Cyndi A. Mart						e, Walke				Code) 21793
0 80 2 2	20e. Method of Disposition 1	Removel from Stete	Plece of Disponentery, creating Oliver	emetory or	other ple	y, Sept.	Date 21, 1999		Location · Co		m, Stete Iaryland
Baitim permit. Pag Department important: t any injury o	21. Signeture of Funeral Service Lice	MOO2					ord P.A				21701
	23a. Part1. Enter the diseese, or com shock, or heert feilure. List only			nter the mo	de of dyir	ng, such as ca	rdiac or respiret	ory errest,	LCR, I		Approximete
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)									1	Intervel Between Onset end Death
		Due to (or as a conse	quence of	5 :				,	1	0
bet Insit						474	0 6	4	104	2	270
58760, cate be executed physician end s the buriel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to to	or es a conse	quence or):						
68760, ficate be expension is the burie	Cause (Diseese or Injury thet initieted events	C. Due to /c	r as a conse	auanca of	١.					-	
'	resulting in death) Last	200 10 (0	1 43 4 00130	qualita of	,						
BOX seth cert attending for use		d								1	
deeth cer deeth cer e attendir ed for use	Pert II. Other significant conditions	contributing to death but not res	ulting in the	undarhina	cause air	on in Part I	23h	Did tohec	co use cont	ribute to	the cause of death
D.O. hat the detached by the d	É	onthibuting to obath but not res	olung in the t	underlying	cause giv	en in Perti.	230.	1000			ably 4 Unknow
of Vital Records, P.O. Physician: The law requires that the de this certificate has been signed by the rel director, page 2 should be detached	Completed by							Wes an eu performed		com	re autopsy findings ilable prior to apletion of cause leath?
The law ate has b pege 2 s	E							1 ☐ Yes	2 No		Yes 2□ No
Vital ician: Th certificate rector, per						26 Place of	Death (Check o				100 2010
Of Vita Physician: this certific red director.	exeminer?	Hospitel: 1 Inpatient 2	ER/Outpatie	ot 3 🗆 🗆	OA Oth				6 □Other	/Snecity	1
Physic refers to the second of	-	28e. Dete of Injury	28b. Time o		28c. Injur		-		njury occurre		/
Affer Ship	Netural 5 Pending investigatio	(Month, Dey Year)	Injury	М		1k? Yes 2 ☐ No					
Division of after death. I prector: After the in by the funere	27. Menner of Death 1 Netural 2 Accident 5 Pending investigatio 3 Suicide 6 Could not be determined		ome, ferm, st by)	treet, fecto	ry, office			ion (Street r Town, St		or Rural	Route Number,
2500	29e. Certifier 1 Certifying Pt	ysician: To the best of my kno niner: On the basis of examine and manner steted.	wledge, deal	th occurrenvestigation	d at the tir n, in my o	ne, date and p pinion, death	place, and due to occurred et the t	the cause ime, date	e(s) and men end pleca, er	ner es sta nd due to	ated. the cause(s)
omp omb	29b. Signeture end title of certifier	Annual Control Control		2	9c. Licens	e number		29d.	Date signed	(Month, E	Day, Year)
F > F 0		>/			D146	526		Sep	tember	17.	1999
	30 Name and entrace of passes in the	completed cause of death (11-	n 22cl /Tim-	Deima)				1		,	
	30. Neme end address of person who				th C+	reat	Frederi	ck M	[9747] 6*	nd 21	701
Ctoto	P. Gregory Rau 31. Date filed (Month, Dey, Year)	32. Registrate Signal		even.	LII SI	reet,	rrederI	ال و١٠٠	ar y I al	iu 21	.701
State Registrar	0000	1999	مير	19.	1	no. V	,				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

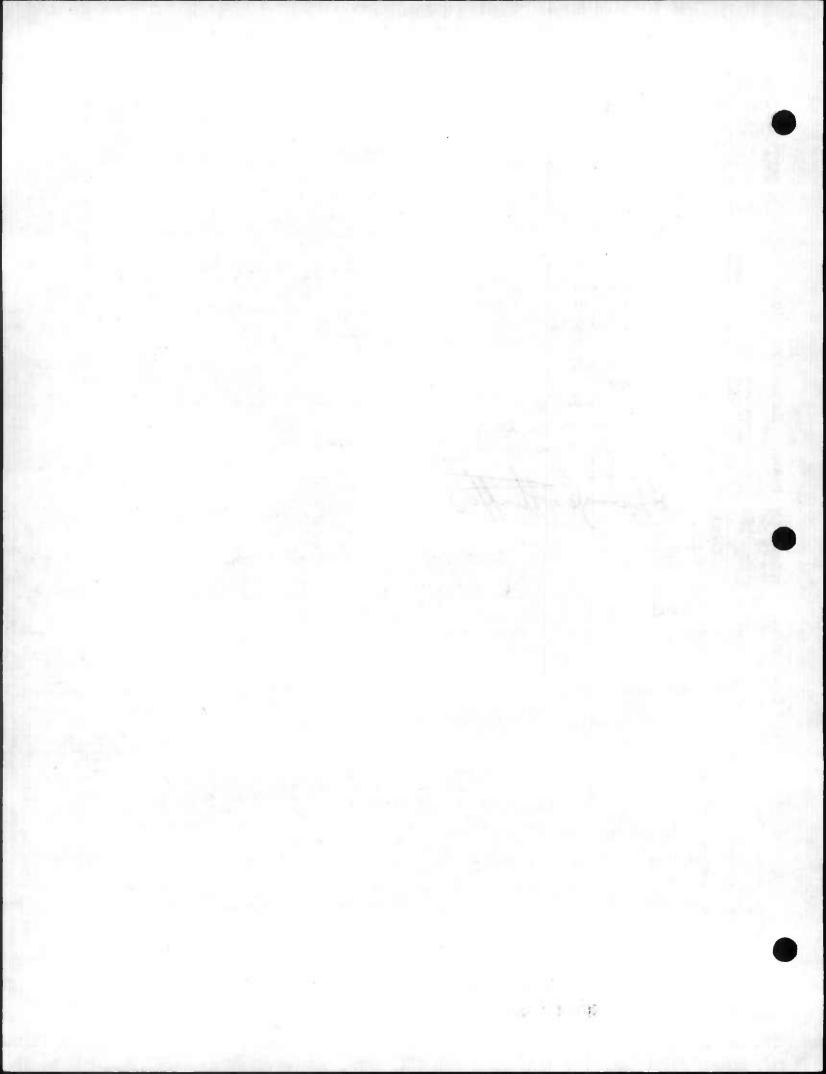
		Certificate of Death	Reg. No. 99 31792
	1. Decedent's Name (First, Middle, Last)	2. Date of	Death 3. Time of Death
Physician	ROBERT L.	BOWERS Sept.	21, 1999 8:15 AM
/Medical Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Do	
LAGITITIE	7006 Wood Court	Thurmont	Frederick
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. las		Birth Oay, Year) 9. Birthplace (State or Foreig Country)
Director	215-34-2855 1 M 2 □ F 61	Yrs. Months Deys Hours Min. (Month, June	
ith the Maryland or 28a-f show a notified at		Town or Location	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
octo de M		mont	
vith the Ma or 28a-f a be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
rall rall	7006 Wood Court	21788	United States
be filed within 72 hours after death with the Maryland tal Hyglene. tal Hyglene. d other than "natural", or terms 23a or 28a-f show avent, the Medical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ② Yes 2 □ No 1958 If Yes, Give Year or Dates: -1961	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify:	No- 14. Race - American Indien, Black, Whita, etc. Specify: white
ed within 72 hours at yglene. The frame fr	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
d within		Mail Carrier	US Postal Service
be filed d other vent, i	17. Father's Nema (First, Middle, Last)	18. Mother's Neme (First, Mid	dle, Maiden Sumeme)
d 2 should be filed th and Mental Hygi 7 is marked other traumatic avent.	Joseph A. Bowers	Alice L. Te	yeryar
should ind Men umarke	-	19b. Mailing Addrass (Street and Number or Rural Routa Nu	
DEL		7006 Wood Ct., Thurmont, Ma	
) - T E E	20a Method of Disposition 20b Plac	e of Disposition (Name of Date	20c. Location - City or Town, Stete
semit. Pages 1 ar Separtment of Hea mportant: if Itam iny Injury or other	1 M Buriat 2 Li Cremetion 3 Li Removel from State	e Ridge Cemetery 9/24/9	9 Thurmont, Maryland
permit. Pages Department of the important: If he any injury or of pince.	21. Gronature of Funeral Seguce Licensee	22. Name and Address of Facility Stauffer Funeral Homes,	
	23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line.	104 E. Main Street, Thur	
Examiner Examiner Examiner	b	s a consequence of):	Cancer 5 m.
fficats be g physicia as the bur ledical	il any, leading to immediate cause. Enter Underlying Cause, Disease or injury	s e consequence of): s e consequenca of):	
death certifica e attending ph of for use as t	d		1
0 0 2 2	Pert II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I. 23b. D	Old tobacco use contribute to the cause of death Yes 2 No 3 Probably 4 Unknow
requires hould be been sign			Ves an autopsy erformed? 24b. Were autopsy findings available prior to completion of cause of death?
The law ate has by page 2 s			
C Parts			Yes 22 No 1 Yas 22 No
certificate rector, par	25. Was case referred to medical examiner?	26. Place of Death (Check on Other:	
His His	1 Yes 2 YNO 1 Inpatient 2 ER	VOutpatient 3D DOX 4D Nursing Home 52H	lesidence 6 □Other (Specify) ibe how injury occurred
tel or Attending Purs after death. rel Director: After tiled in by the funeri	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, street, factory, office 28f. Location City or	on (Street and Number or Rural Routa Number, Town, State)
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in DM Medical Certi	29e. Certifier (Check only Check only Check only Check only	dge, death occurred et the tima, data and place, and dua to l a and/or invastigation, in my opinion, deeth occurred et the tin	ha cause(s) and mannar as stated. ne, date end plece, and due to the ceuse(s)
To the within To the comple	29b. Signature and little of certifies M	29c. License number	29d. Date signed (Month, Day, Year) 9-23-99
	3d Name and address of person who completed cause of death (Item 23	Sa) (Type, Print) 501 W 7th St	rect Frederick, MD
State Registrar	31. Date filed (Month, Day Fp) 2 4 19 32. Registrary Signature	La de	2/18



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dey Month **Physician** 3:45P.M. **JACOB** Sept. 24, 1999 BARTLETT /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Health Care Center Frederick Frederick If Under 1 Year If Under 24 Hrs. Sex 100 M 2 F 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-50-7502 82 Director May 7, 1917 Maryland Usuel Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits *ohe r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at Maryland Frederick Frederick Director 1 Yes 2 □ No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 462 W. South St. 21701 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

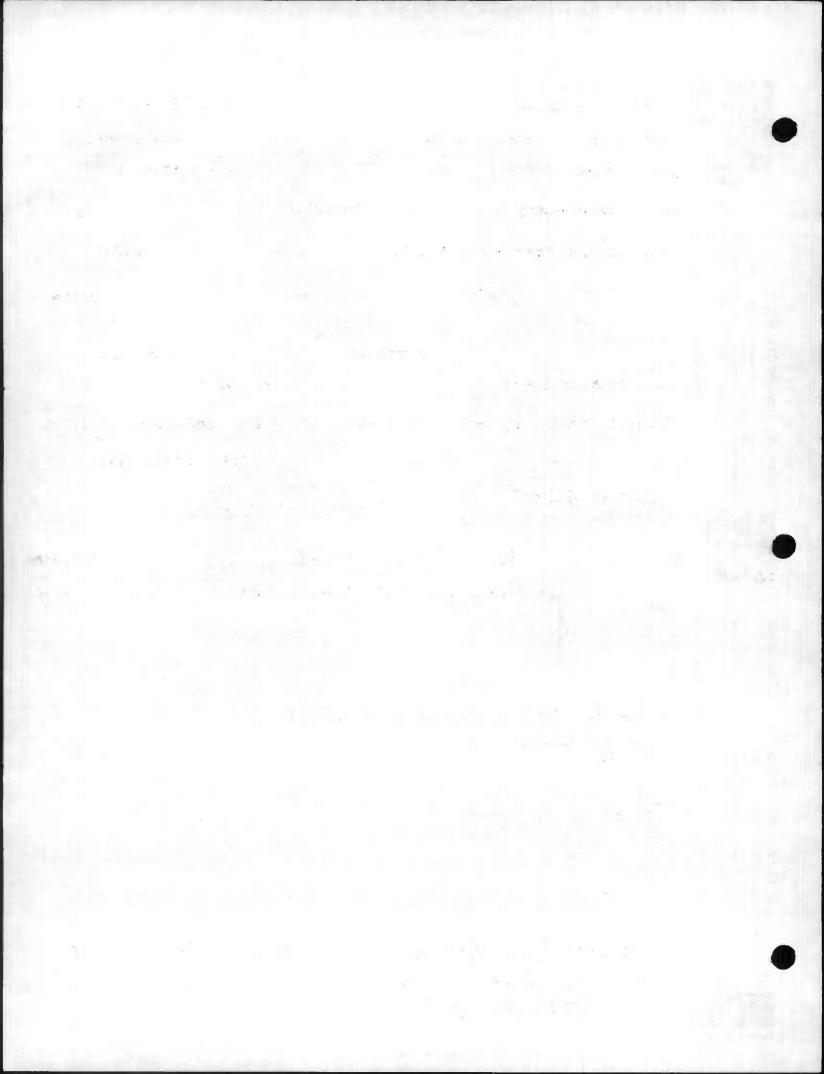
Disportant: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Hodgell Barrier pages. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 N Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Huckster 3 Produce 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Lester Bartlett OL unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) Diane M. Underwood / Daughter 200 Chapel Ct., Unite 324, Walkersville, MD 21793 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel trom Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9-27-98 Libertown, Maryland Fairmont Cemetery 21. Signeture of Funerel Service Commence 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 Pert # Enter the disertal, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellum. List only one cause of each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) **Examiner** Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting In death) Last Due to or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of): 980 P.O. signed by the a 23b. Did tobacco use contribute to the cause of death? Pert tt. Other atgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy tindings aveilable prior to Be Completed 24a. Wes en eutopsy performed? completion of ceuse of death? s certificate has t 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien: 24 hours after death.
 Funeral Director: After this certifical eleity filled in by the funeral director, I 25. Wes cese reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Neturel 5 Panding 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medical 29a. Certifier completely (Check only one) within 2 To the F 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 1475 TANEY AVE #204 FREDEK FREDERICK 31. Dete tiled (Month, Dev. Yea 32. Registrar's Signature State 1999 Registrar

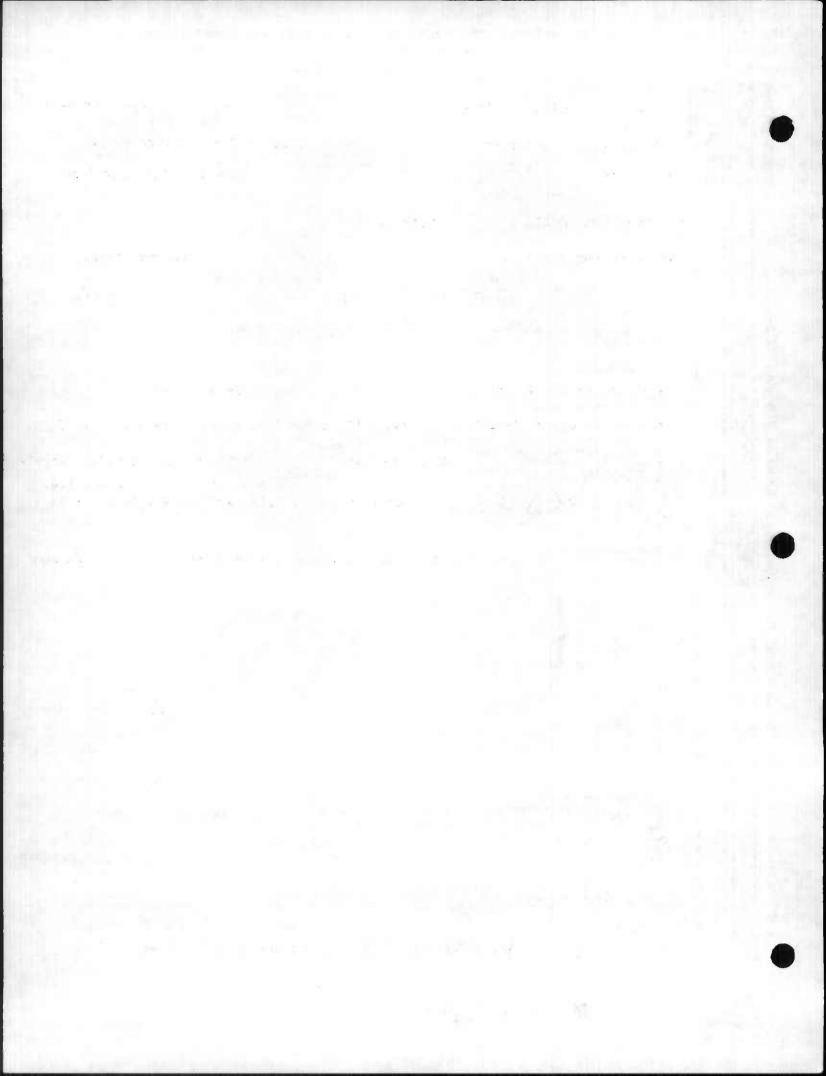


State of Maryland / Department of Health and Mental Hygien Q 21701.

					Olato o	· ·····	y latta /		rtificate o	f Death		Reg. No.	0 1	194
	Sh		1. Decedent's Nama (First, Mid	die, La	st)						2. Data of De		Vear	3. Time of Death
	Physicia /Medica		IDA D. BI	URR	ESS						Sept.		9 9 3 3'	5:45 pm
N	Examine		4a Facility Name (If not instituti							4b. City, Town, or	Location of Deat	100	ty of Death	
			Montgomery						If Under 1 Ye	Olney	10.5 1 -(5)		gome	-
	Funeral Director		5. Sociel Security Number 214-48-6540 Usual Residence of Decedent	6. S	ex □M 2⊠F	7. Age (/	ln yrs. last bi	Yrs.	Months Day	ys Hours Min.		1919	9. Birthp Cour VA	place (State or Foreign ntry)
	Meryland -1 show	tor	10a. State MD Monte		ery	10	Oc. City, Tov	vn or Lo	Roc	kville			1	0d. Inside City Limits 1X Yas 2 No
	h with the	Funeral Director	10e. Street and Number 16116 Crabb	s B	ranch	Way	/Apt	12	10f. Zip Code	20855		10g. Citizen o	S.A.	ntry?
21215-0020	urs a	2	11. Marital Status 1 □ Naver Married 2X Ma 3 □ Widowad 4 □ Divorce		12. Was Dece Armed Fo 1 Yas If Yes, Giv Year or D	rcas? 2 12 No	ar in U,S.	1	Was Decedant of If Yes, specify C 1 ☐ Yes 2€ N	of Hispanic Origin? (Suban, Mexican, Puer lo Specify:	Specify Yas or No to Ricen, etc.)	Spec	ace - Amaric ack, White, ify:	
5-0	72 hc natur	To Be Completed	15. Decede (Specify only high	ent's Ed	ducation de completed)		168	. Dece	dent's Usuel Occ	cupetion ne duning most of wa ired)	rking	16b. Kind of	Business/In	dustry
121	vithin ne. nen	E I	Elementery/Secondary (0-12	1	College (1	-4or 5+)				ired)				
2	tygie tygie frer ti mt, m	S	4 17. Father's Name (First, Middle	a / ast			H	ous	ewife	18 Mother's Ne	me (First, Middle		estic	
an	d be sental	e e	John Jackso								Myers			
Maryland	shoul mark mark	-	19a. Informant's Name/Relation	nship (Type, Print)		19	b. Mailir	ng Address (Stre	eet end Number or R	ure / Route Numb	er, City or Tow	n, Stete, Zip	Code)
	eith e	ļ	Kathy Burre	ss-	-daugh	ter	2	103	West	Side Dri	ve Fre	derick	, MD	21702
Baltimore,	of He of He rothy		20a. Method of Disposition 1 ⊠ Burial 2 □ Cramation		Damaual from	Ctata			sition (Neme of metory or other p		Date	20c. Location		
Ĕ	Pag ment: H ury o	ŀ	4 Donation 5 Other			Stata	Mono	cac	ЗУ	(9/27	Beall	svill	e, MD
Salt	Depention Depending Injury Inj		21. Signature of Funeral Service	e Licer	isee			22	Name and Ad	dress of Facility Funera	Homo			
_	70 F # 9	_	win CI	lel	£				Barnes	ville.	MD 2083	8		
			23a. Part1. Enter the disease, shock, or heart failure. Li	or com st only	plications that c one cause on e	aused the ach line.	e death. Do	not ent	er the mode of o	tying, such as cardia	c or respiratory a	rrest,	1	Approximate interval Between
Y	Physician /Medical		Immediate Cause (Final										1	Onset and Death
B	Examiner		disease or condition resulting in death)		. Hae	MON	rhay	nc	Shr	ske			- 1	4 days
		ē			C	Du	e to (or as a	consec	quence of):	Ke			9	4 days
	ifficate be executed g physicien end es the buriel-transit	edical Examiner	Sequentially tist conditions.		b. Yra	LUL_ Du	e to (or as a	consec	quence of):	craw				3 days
0,	tificate be execut g physicien end es the buriel-tran	K	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events										1	
68760,	ohysic the b	dica	thet Initieted events resulting in death) Last	1	C,	Du	e to (or as a	conseq	juance of):				1	
	\$ O 0			L	d									
Вох	death cert e ettendin ed for use	San											1	
P.O.	that the death cer ed by the ettendir deteched for use	Physician/M	Part II. Other significant condi							-				o the cause of death? bably 40/Unknown
	that hed by dete	Dy F	Acute	14	ntero	at	eral	NU	10 care	deal	10	Yes 2 No	3 ☐ Pro	Dably 42 Onknown
Vital Records,	The law requires that the site hes been signed by the page 2 should be deteched.	Completed	Infare	ti	on	9			'			an autopsy ormed?	av	fere autopsy findings vailable prior to empletion of cause death?
æ	The law te hes sege 2	E									10	Yes 2 No	11	□Yes 20 No
ţ	certificate rector, pag	Se C	25. Wes case referred to medic examiner?	cal						26. Plece of De	eth (Check only	one)		
of <	Physician: this certific ral director,	0	1 ☐ Yes 2 No		Hospital: 1	npatient	2 ER/0	utpetier	II 3L DOA		Home 5 ☐ Res			fy)
n	Ing P	5	27. Manner of Death 1 Naturat 5 ☐ Pend		,	of Injury th, Dey Y		Time o Injury		njury at Vork?	28d. Describe	how injury occ	urred	
Sic	or Attending I after death. Director: After I in by the fune	Cat	3 Suicida 6 Coul		B OD- Dinos	of Inium	At home f	om et		Yes 2 No	28f Location	Street and Nu	nher or Run	el Route Number,
Division	after Direct in by	Certification:	4 Homicide dete	mined	buildi	ng, etc. (Specify)	aiii, sii	reet, factory, offi	OB .		wn, Stete)	11001 01 1101	, , , , , , , , , , , , , , , , , , , ,
ŀ		edical C	29a. Certifier (Check only one) Certify	ring Ph al Exan	ysician: To the niner: On the be	esis of ex	amination a	e, deati	n occurred at the vestigetion, in m	tima, date and plac y opinion, deeth occ	e, and due to the urred at the time,	cause(s) and date and plac	menner as s e, end due t	stated. o the ceuse(s)
	vithin To the	Z E	29b. Signature and title of certif	fiar					29c. Lice	ensa number		29d. Date sig	ned (Month,	Day, Year)
	- > Pr U		> Ames	Ld	001.1	007	o n	100	D >	8260		Sept	24	1999
		-	30. Name and address of person	n who	completed caus	e of deat	h (Item 23a)	(Type,	Print)	, 3 2			^	10800
			Dr A. MEN	DI	PIRAT	TA	2	40	1 Rese	arch B	cvo Su	To 340	Koc	curle MD
	Stat		31. Date filed (Month, Dev Year	B 2	7 1000 B	egistrar's	Signature	~						
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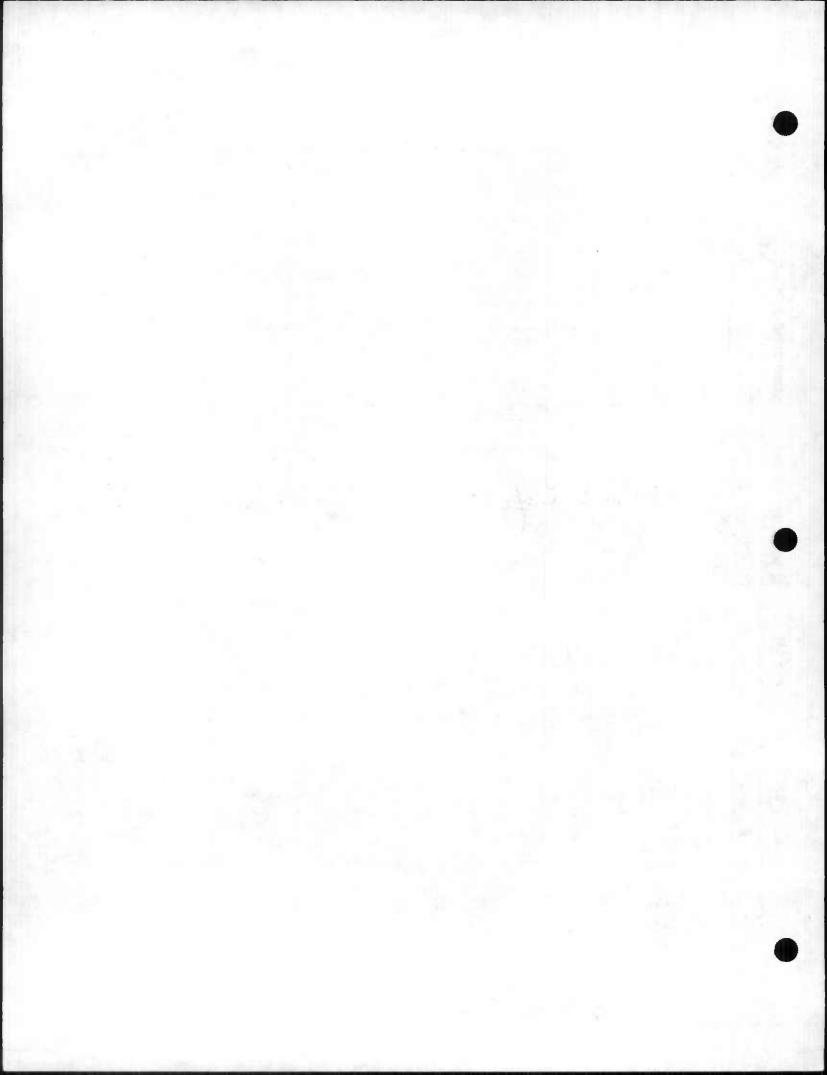


				Certifica	te of l	Death		Reg. No.			
1. Decedent's Name	(First, Middle, Las	(1)				M.C.	2. Date of		- Mar	3. Time of Death	
hysician LaRue	Annabe	11e Bro	พา				Sept.	27, 1	999	9:45 AM	
/Medical					4	4b. City, Tov	wn, or Location of D		unty of Death	7113 121	
.xammer						Mo 11	ersville	E-	rederic	1e	
E Copiel Copusity Nus	rederick		e (in yrs. last b	airthday) If Unc	er 1 Year	If Under a				place (State or Foreign	2
rai	1[□M 2K)E	83	Yrs. Month	Days	Hours	Min. (Month,	Birth Day, Year) 11, 191	Cour	ntry)	
214-10-356 Usual Residence of D			0.3				pune	11, 1916 Maryland			-
	10b. County		10c. City, To	wn or Location					1	Od. Inside City Limits	
Ö 1/2 1	The 1 - 1 - 1 -	1-	77-	11 1	1 -					Yes 2 No	
Maryland 10e. Street and Numb	Frederic	: K	wa.	lkersvil	Te Code			10a Citizan	of What Cour	nto. 2	-
				101. 2	-						
42 W. Fre	ederick S					1793		1	d Stat		
11. Marital Status		12. Was Decedent Armed Forces?		13. Was Dec	edent of H ecify Cuba	an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No- 14.	Race - Americ Black, White,		
		1 ☐ Yes 2XO	No	1 ☐ Yes	20 No	Specify:		Sp	ecity: wh	ite	
3XXWidowed 4		Year or Dates:									
(Specify Elementery/Second 8th	 Decedent's Edition only highest grad 	ucation de completed)	16	 a. Decedent's Use (Give kind of second control of secon	vork done i	durina most	t of working	16b. Kind	ot Business/In	dustry	
Elementery/Second	dery (0-12)	College (1-4or	5+)	life. DO NOT		d)					
8th				Homer	naker				Own		
17. Father's Name (F	irst, Middle, Last)					18. Mothe	r's Neme (First, Mic	ldle, Maiden Su	mame)		
	Maurice	Haugh				Min	nnie Bell	e Biser			
19a. Intormant's Nam	ne/Relationship (7	ype, Print)	15	b. Meiling Addre	ss (Street	and Numbe	er or Rural Route Nu	mber, City or To	own, Stete, Zip	Code)	
Dr. Dawn	L. Brown	n, daughte	er	14219 (ttor	Run I	Road Tal	lahasse	e, Flor	rida 32312	
20a. Method ot Dispo			ceme	of Disposition (A	ame of		Date		lon - City or To		
	Cremation 3 1	Removal from State		e Cemete		,	9/30/9	99 Wall	cersvil	le, Maryla	a r
21. Signature of Fune			Oladi		-	ss of Facilit	h/	-			41
(X)	//	1	0				Stauffer			s, P.A.	
Han	y X.	Vous	96				Valkersvil		cyland	21793	
23a Party. Enter the shook, or heart	Milure. List only o	one danse on each	ne cream. De	o not enter the m	ode or dyin	ng, such as	cardiac or respirato	ry arrest,		Approximate Interval Between Onset and Death	
/ /	7.1	0								Oriset and Death	
Immediate Cause (Fi	inal	NOT	DUAR S	CLEROSIN	G HOT	JEKWS	LYMPHO.	MA		7 years	
resulting in death)				a consequence o							
Sequentially list cond if any, leading to imm cause Enter Underb		b									
Sequentially list cond if any, leading to imm	ditions,		Due to (or as	a consequence o	1):						
	ying	^									
Ceuse (Diseese or In that infliated events resulting in deeth) Le		V	Due to (or as a	consequence o	i):						
We will be with a second and a second a second and cond and											
		o							I		
Part II. Othar significa	ant conditions co	ontributing to death b	out not resulting	in the underlying	cause giv	ren in Pert I.	. 23b.	Did tobacco us	a contributa t	o the cause of death	?
Part II. Other signification								□ Yes 2	No 3□Pro	bably 4 Unknow	'n
Ž											
8								Vas an autopsy	24b. W	fere autopsy tindings	
Completed							F	erformed?	CC	vailable prior to empletion of cause death?	
								- J			
							1	□ Yes 2	No 1	☐ Yes 2☐ No	
25. Was case reterre examiner?		Manakati			-		ot Deeth (Check o	nly one)			
1 Yes 2 N	io	Hospital: 1 Inpati	ent 2 ER/0	Outpatient 3□		4 LI NU			Other (Speci	fy)	
27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	ly Year) 28b	. Time ot Injury	28c. Injur Wor	rk?	28d. Descr	ibe how injury o	ccurred		
2 Accident	investigation			M		Yes 2	No				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	208. Place of In	jury - At home,	tarm, street, fact	ory, office			on (Street and to Town, State)	Vum <i>ber</i> o <i>r Rur</i>	al Route Number,	
27. Manner of Death 1/2 Hatural 2 Accident 3 Suicide 4 Homicide		bullding, en	tc. (Specify)				Only of	. 5, 0.000/			
	Certifying Phy	vaician: To the best	ot my knowled	ge, deeth occurre	d at the tin	me, date an	d place, and due to	the cause(s) ar	nd menner as	stated.	
29a. Certifier 1 (Check only 2 one)	Medicai Exam	lnar: On the basis of and manyler st	t examination a	and/or investigati	on, in my o	pinion, dea	th occurred at the ti	me, date and pl	ace, and due t	o the cause(s)	
29b. Signature and tit	itle of cepillar	7/			9c. Licens	se number		29d. Date !	signed (Month,	Day, Year)	
L	<	/// ^	2		1	37.	-		2/27/	ce	
	1	V /	ソ		リ	321.	11		11211	77	_
30. Name and address	ss ot person who o	completed cause of	death (Item 23a) (Type, Print)							
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24 Data filed /Manth		O BON 328	WAL	KURSUIL	mo	2179	43				_
te 31. Date filed (Month,	Day_Year)	32. Regist	rar fignature				13				
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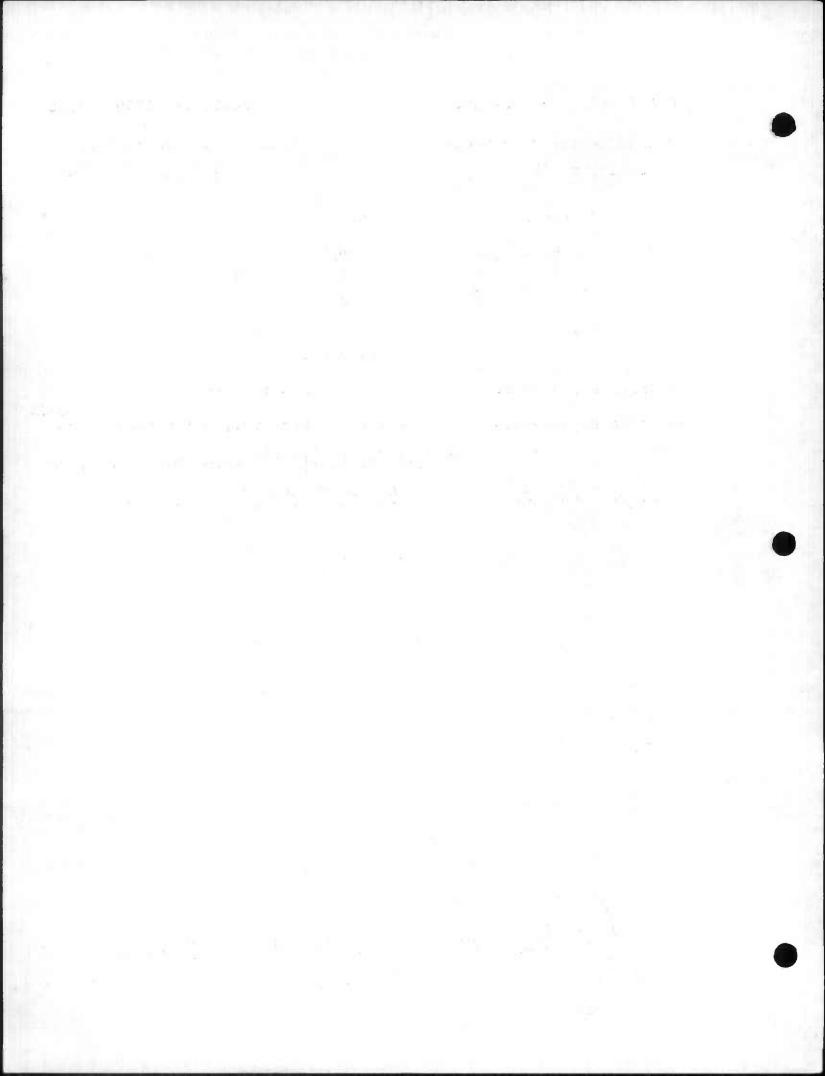
State of Maryland / Department of Health and Mental Hygiene 99 3 | 796

		Certifica	te of	Death		Reg. No.			
1. Decedent's Neme (First, Middle, Last)					2. Dete of Month			3. Time of C	
Physician Raymond Richard		Bas	ford			ember	17, 1999	4:10	
Examiner 4a Facility Name (If not institution, give street and number)			4	b. City, Town,	or Location of D	eath 4c.	County of Deeth		
Northampton Manor Nursing	Center	•		Fred	erick		Freder:		
uneral MZIM 2DE	n yrs. last birtho	Months	er 1 Year Deys	Hours M	in. (Month,	Day, Year)	9. Birth	olece (Stete or	
Usual Residence of Decedent	90				Nov.	12, 1	.900 Mary	Tand	
10a. Stete 10b. County 10	C. City, Town o				10d. Inside City Limi				
Maryland Frederick	Frederi	.ck						1 X Yes 3	
Maryland Frederick 10e. Street and Number		10f. Z	ip Code			10g. Citi	zen of What Cour	ntry?	
200 East 16th Street			217	01		U.S	S.A.		
200 East Toth Street 11. Merital Stetus 12. Wes Decedent Eve Armed Forces? 1 Never Married 2 Merried 1 Yes 2 M No	r in U,S.	13. Was Dec If Yes, sp	edent of Hecify Cube	lispanic Origin? en, Mexican, Pu	(Specify Yes or erto Rican, etc.)		14. Race - Americ Bleck, White,		
If Yes, Give		1 ☐ Yes	2 X No	Specify:			Specify: Whi	ite	
3 N Widowed 4 Divorced Yeer or Detes:	16a D	ecedent's Us	uel Occup	etion		16b Ki	nd of Business/Inc	dustry	
(Specify only highest grade completed)	10	Give kind of wife. DO NOT	ork done	during most of v	vorking	100. Ki	TO OF DUSINGSSAIN	dustry	
Elementary/Secondery (0-12) College (1-4or 5+)	Da	airy Fa	rmer			Fa	arming		
17. Father's Neme (First, Middle, Last)				18. Mother's N	lame (First, Mic	dle, Maiden	Sumeme)	-1.	
Albert Bowers Basf	ord			Fanni	e Virg	inia	Stonebu	rner	
19a. Informant's Neme/Relationship (Type, Print)	19b. N	Mailing Addres	ss (Street	and Number or	Rural Route Nu	mber, City o	r Town, Stete, Zip	Code)	
Mrs. Rebecca A. Harbaugh, Dau	ghter	2548 I	Bear :	Den Roa	d, Fred	erick,	, Md. 21	701	
42	20b. Place of D cemetery,	cremetory or	other pled	ce)	Date		cation - City or To		
5 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify)	Mount C	livet C	meter	y, Sept.	20, 1999	Fre	ederick,	Maryla	
4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee		22. Neme 8	ind Addre	ss of Facility	nd D A	Ermor	ral Home		
Kichows E. JAW MOO2	.55							21701	
23a. Part1. Enter the diseese, or complications thet caused the shock, or heert failure. List only one cause on each line.	deeth. Do no	t enter the mo	de of dyin	g, such as cerd	iac or respirator	y arrest,	III.	Approximate Intervat Between	
cian								Onset and De	
ical tmmediate Cause (Finel disease or condition	- STAGE	- A -	7 11 -50 A	ners D	150085			5	
Due Due	e to (or es a co	The second second		- CO NESS D	()0000			5 year	
Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due							1		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	e to (or es a co	nsequence of):						
Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury							1		
Cause (Disease or injury that initiated events resulting in death) Last	to (or es a cor	nsequence of):						
d							į		
								1	
Pert II. Other significant conditions contributing to death but no	ot resulting in th	he underlying	ceuse giv	en in Part t.			vae contribute to		
id Aq					_	☐ Yes 2	UBUNO 3 Pro	bably 4□U	
a (q						/es en autop		ere autopsy fin	
Completed					- P	arformed?	co	aiteble prior to impletion of ca deeth?	
00					1	☐ Yes 2		□Yes 2□N	
25. Was case referred to medical			_	26 Place of F	eath (Check or				
O 1 Yes 2 Thio Hospital:	2 ER/Outp	atient 3 C	OA Oth	- 1			8 Other (Specif	(v)	
		ne of	28c. Injun Wor		7	be how injur		,,	
1 Netural 5 Pending (Month, Day Ye	sar) Inju	M		Yes 2 □ No					
1 Netural 5 Pending (Month, Dey Ye 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Plece of Injury-building, etc. (S	At home, farm	n, street, fecto	ry, office			n (Street en Town, Stete	d Number or Plum	al Route Numb	
27. Manner of Deeth 1 Netural 2 Accident 3 Sulcide 4 Homicide 28e. Date of Injury (Month, Dey Ye building, etc. (S	pecity				Only of	rown, broto,	,		
29a. Certifier Check only one) 29a. Certifier Check only one) 2 Medical Examiner: On the best of examiner steted.									
		or investigation	n, in my o	pinion, death oc	curred at the til	ne, dete end	piece, and due to	o trie cause(s)	
29b. Signeture end title of certifier		2:	9c. Licens	e number		29d. Dat	te signed (Month,	Day, Year)	
(m)			D321	L71		Sept	ember 17	, 1999	
						_		,	
30. Neme and address of parson who completed cause of deeth	(Item 23a) (Ty	ype, Print)					. 7		
30. Neme and address of parson who completed cause of deeth Richard L. Gough, M.D., 19 State 31. Dete filed (Month, Dey, Year) 32. Registrate 32. Registrate				Street,	Walkers		. 7		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Q 17 Q 7

Deceder's New Prize, Modification CLARK WESLEY BOYER, SR. Sept. 17 Prival 1998 3. Time of Death (CLARK WESLEY BOYER, SR. Sept. 17 Prival 1998 7:00 and No. Clark Wesley Sept. 17 Prival 1998 3. Time of Death (CLARK WESLEY BOYER, SR. Sept. 18 Prival 1998 3. Time of Death (Sept.					State of Ivid	arylanu /		tificate of	neaith and it Death		Reg. No.	J	1191
The Colon of the Care Center Sould Search Vision Four Assistance Progress Progr										2. Dete of De	ath		3. Time of Death
## Security Number of An Evoluty Number of An Evoluty Number of An Evoluty Number of Annex Security Number of Annex Secur				CLARK WESLEY	BOYER, SI	₹.				Sept.	17 ^{Pey} 19	ga,	7:00 am
Second Security Number 1)			4a. Fecility Neme (If not institution, given	re street end number)				4b. City, Town, or L	ocation of Deeti	4c. County	of Death	
Special processor Spec				Wilson Health	Care Cer	nter			Gaither	sburg	Mont	gome	ry
10.5 State 10.5 County 10.5 State and hambar 10.7 County 10.7 Co				214-16-7297	Seef as a man					8. Dete of Bir (Month, De Dec 5	th v, Year)		lece (State or Foreign try)
Body Body		pue M				10c. City, Tow	vn or Loc	ation				1	Od. Inside City Limits
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The Color of the second property of the color of the colo		or 284	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
Body Body		th wil	al D	15812 White Ro	ock Road			2087	8		U.S.	Α.	
Body Body	020	ours after dea al', or items Examiner m	Ď	1 Never Married 2 Merried	Armed Forces? 1 Yes 2 1					ecify Yes or No Rican, etc.)		k, White,	etc.
Body Body	5-0	72 ho	eted	15. Decedent's E	ducation	16e	. Deced	ent's Usuel Occup	pation	rina	16b. Kind of Bu	siness/Inc	dustry
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Physician Micecles (Final disease or condition resulting in death) Post Physician P				23a. Pert1. Enter the disease, or com shock, or heert tailure. List only	plications thet caused one ceuse on each iir	the deeth. Do	not ente	r the mode of dyir	ng, such es cardiec	or respiretory e	rrest,	0.00	Interval Between
Dus to (or se a consequence of): Dus to (or se a consequence of):					0				~·				Onset end Death
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24a. Wes en eutopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 25. Wes case ratarred to medical aximiner? Or death? 26. Place of Death (Check only one) 27. Manger of Deeth 1 Inpatient 2 EP/Outpatient 3 DOA 27. Manger of Deeth 1 Alatural 5 Pending Investigation 3 Suicide 4 Homicida 5 Pending Investigation 3 Suicide 4 Homicida 5 Pending Investigation Ö	t the	hys					sonying odoso gn	TOTAL TOTAL		/			
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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and piece, end due to the ceuse(s) and manner es stated. 29b. Signature and title of certifier (Check only one) 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piace, end due to the cause(s) and manner es stated. 29c. License number 29d. Dete signed (Month, Day, Year) September 17, 1999 30. Nems and eddless of person who compiated cause of deeth (Item 23a) (Type, Print) September 17, 1999 30. Nems and eddless of person who compiated cause of deeth (Item 23a) (Type, Print) September 17, 1999 31. Date filled (Month, Day, Year) 32. Rangistrant, Sgnature	/ita	stan: octor,							26. Placa of Deat	h (Check only o	one)		
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29a. Certifier (Check only and manner setated. 29b. Signature and title of courtier 29c. License number 29c. License number 29c. License number 29d. Dete signed (Month, Day, Year) 30. Nems and eddless of person who compiated cause of death (Item 23a) (Type, Print) 30. Nems and eddless of person who compiated cause of death (Item 23a) (Type, Print) 31. Defen filed (Month, Day, Year) 32. Rangistrari, Squature	2	ttend death tor: / the	cat	3 ☐ Suicide 6 ☐ Could not b	e one place of let	me Athema te			Yes 2∐No	20t Leastion (Ctonat and Alumb	or or Dum	/ Pauto Number
30. Nems and eddless of person who compiated cause of deeth (Item 23a) (Type, Print) Scal Schulmen, M.D. 9410 Old George town Road, Bethesda, Md State 31. Defin filed (Month, Day Yeer) 2 0.1000. Angistrary Signature	2	sfter Direction	ertif				erm, stre	et, rectory, onice		City or To	wn, State)	er or Hura	r Houte Number,
30. Nems and eddless of person who compiated cause of deeth (Item 23a) (Type, Print) Scal Schulmen, M.D. 9410 Old George town Road, Bethesda, Md State 31. Date filed (Month, Day Yeer) 2 0.1000. Angistrary Signature		Mospita 24 hours Funeral etely filled	_	(Uneck only Medical Exam	niner: On the basis of	examinetion en	e, deeth nd/or inve	occurred et tha tirestigetion, in my o	ma, data and piece, pinion, deeth occur	end due to the red et the time,	ceuse(s) and ma dete end piace,	inner es st end due to	ated. the cause(s)
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State 31. Date filed (Month, Day Yeer) 32. Registrary Signature				30 Nome and addition	/h_/	7 V	(T) =	02	0578	4	Septem	ber	17, 1999
State 31. Date filed (Month, Day Yeer) 32. Registrary Signature								9410 B	d Genso	etown	Road	Bet	hasda, Md.
Registrar SEP & U 1999		Sta	te		32. Angistra	Signature	_	/.	, 200.	-, - , -, -, -, -, -, -, -, -, -, -, -,	, , , , , ,	1	777100
		Registr	ar	SEP 2	0 1999	- Janes		D. p.	park				



Piease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** September 13, 1999 Stanley Edward Clum 1020 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 180 M 2□ F Months Director 193-26-7059 65 Aug. 8, 1934 Pennsylvania Usual Residence of Decedent 10a Stata 10b County 10c City Town or Location 10d. Inside City Limits 28a-f ahow 1 Yas 2 No Director Frederick Maryland Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 21771 Items 23a 15361 Black Ankle Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, Whita, atc. 72 hours after 1 N Yes 2 No
If Yes, Give
Year or Dates: Korea 1 Never Married 2 Married "natural", or 21215-0020 1 Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) Cotiege (1-4or 5+) .. Pages 1 and 2 should be filed will timent of Health and Mental Hygien tant: if item 27 is marked other the jury or other traumatic event, the Electrician Union Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Mildred Elizabeth Walton Stanley Lyman Clum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15361 Black Ankle Road Mt. Airy, Maryland Barbara A. Clum, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cramation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 9/16/99 Mt. Airy, Maryland Pine Grove Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funaral Service Licensee 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part it Enter the disease, or complications that caused the dealty Do not sinter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finei disaasa or condition resulting in death) Arteriosclerotic Cardiovascular Disease Years Examiner Due to (or es a consequence of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate causa. Entar Undarlying Cause (Disease or injury Due to (or es a consequence of): Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? P.O. 3 1 Yes 2 No 3 Probably 4∑ Unknown Hypertension; Coronary Artery Disease signed I Division of Vital Records. by 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Completed Be 2 this funeral Certification: death. within 24 hours after death To the Funeral Director: / completely filled in by the f

25. Was case referred to medical axaminer?

11 Yas 2 No

27. Manner of Death

1 X Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

or Attending Physician:

Hospital

To the I within 2

Hospital: 1 ☐ Inpatient 2 PER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation

28e. Ptace of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and titla of certifier

6 Could not be

29c. License number D35164

29d. Date signed (Month, Day, Year) September 13, 1999

1 ☐ Yes 2 No

30. Nama and address of person who completed cause of death (tem 23a) (Type, Print)

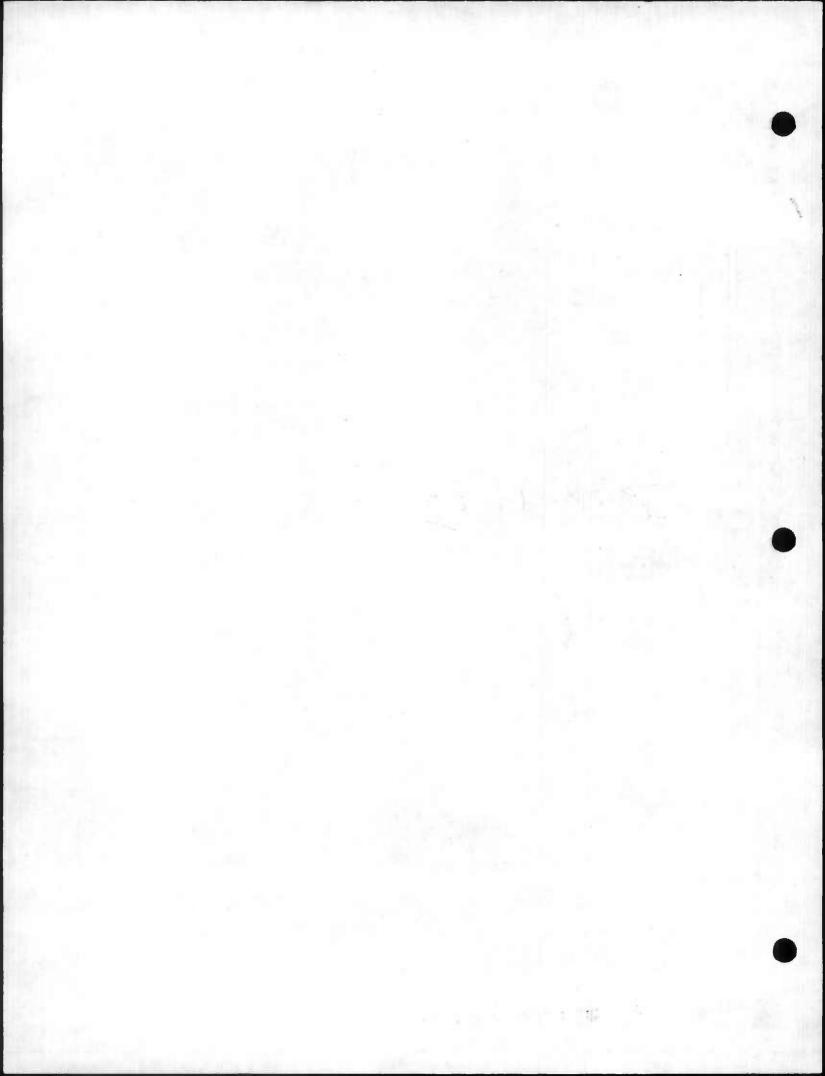
MD, 1080 West Patrick Street, Frederick, Maryland 21703 Andrew Zarick, Jr., 31. Data filed (Month, Day, Year)

State Registrar

Medical

32. Registrar Signatura SEP 1 **199**9

Spark



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Yea **Physician** Anna Creager September 29, 1999
coation of Death 4c. County of Death 9:30 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth 9. Birthplace (State Sept. 26, 1912 Mary Land 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Deys Months Hours 214-10-2730 10 M 20 F Director Uaual Residence of Decedent the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Exeminar must be notified at Frederick Maryland Frederick 1 □XYes 2 □ No Director 101. Zip Code 21702 10e. Street and Number 10g. Citizen of What Country? 1421 Taney Avenue U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hyglane. Important: If frem 27 ie marked other than "natural" any injury or other treumatic events. Black, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: Specify: White þ 3 DWidowed 4 □ Divorced Completed 15. Decedent'a Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Payroll Clerk Power Company 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kleff Edward Paper Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) John M. Creager, Son 1913 Winston Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremetion 3 Removel from State Mount Olivet Cemetery, Oct. 1, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Fecility
Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Pulmonary hour embolism disease or condition resulting in death) Examine Due to (or es a consequence of) Examiner physician and s the burlal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as e consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco usa contributa to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Previous cerebrousscular accidents Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? Parkincons disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending 1 Naturat 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner steted. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Stein MO 30. Name and address of person who completed cause of death (tiem 23a) (Type, Print)

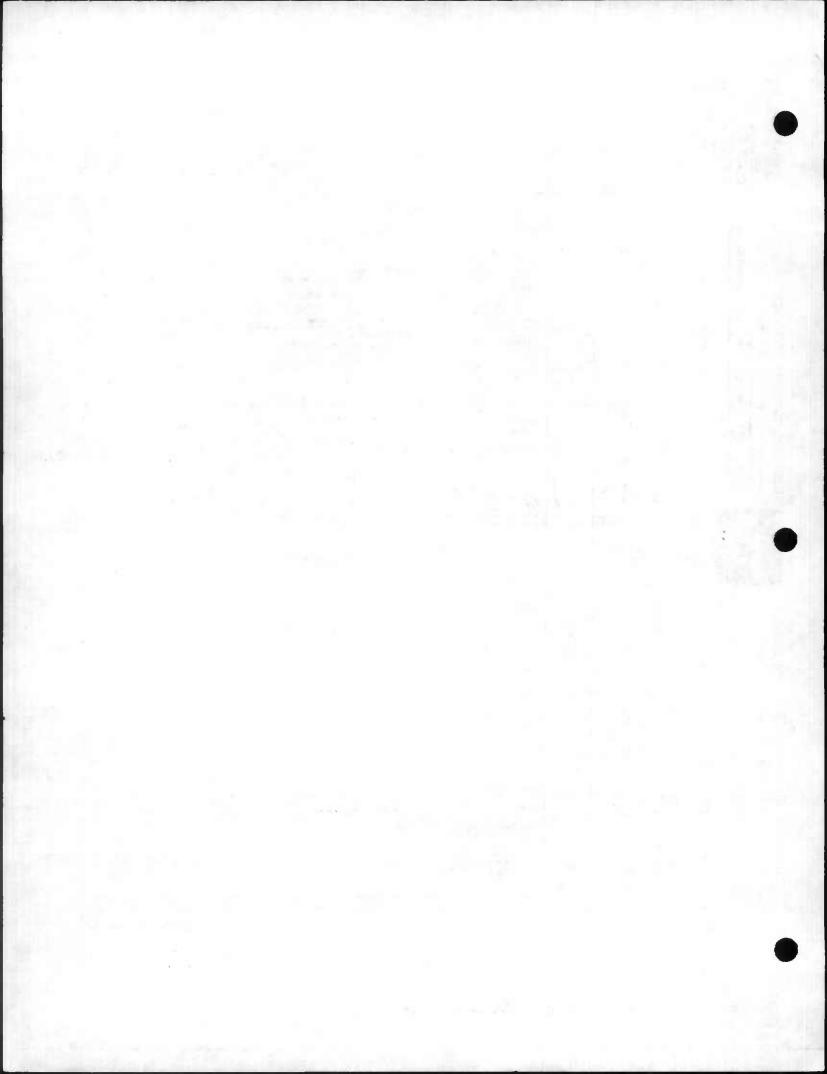
Registrar

State

Ninth Owe

CM

610 32 Registrer's Signeture Brunswick Md 21716



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Yeer September 26, 1999 CHANEY 12:30 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Data of Birth May 21, Year 1920 7. Age (In yrs. last birthday) 79 vrs. 9. Birthplace (Stata or Foreign 1 □ M 2 1 F Mary Tand 10c. City, Town or Location 10d. Insida City Limits Maryland Frederick Frederick 1 ☐ Yas XXNo 10f. Zip Code 21703 10g. Citizen of What Country? U.S.A. 6885 Crabapple Court 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian. Black, White, atc. 1 ☐ Yes 2 X No If Yes, Give Year or Detas: 1 ☐ Yas 2 ☑ No Specify: Specify: White

Rosa

19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code)

6885 Crabapple Court, Frederick, Md. 21703

16b. Kind of Business/Industry

Retail Store

Main

18. Mothar's Nama (First, Middle, Maiden Surname)

16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired)

Audit Clerk

10e. Street and Number 11 Marital Status 1 Never Married 20 Married 3 ☐ Widowed 4 ☐ Divorced

LAVERNA

5. Social Security Number 212-14-6114

10a, Stata

Usual Residence of Decedent

Elementary/Secondary (0-12)

17. Father's Nama (First, Middle, Last) John

19a. Informant's Name/Relationship (Type, Print) Glenn R. Chaney, Husband

10b. County

15. Decedent's Education (Specify only highest grade completed)

Kathleen W Skin MO

SEP 2 7 1999

Kathleen W. Stern MO

31. Data filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrars Signatura

College (1-4or 5+)

Mackenzie

Director Funeral à

Physician

/Medical

Examiner

Funeral

Director

the Meryland

permit. Peges 1 and 2 should be filled within 72 hours effer deeth with the Merylen Department of Heelth and Meniel Hygiene. Important: if hem 27 is marked other than "natural", or hams 23s or 28a-1 show eny lighty or other treumsits event, the Western Examinar must be notified at 9008s.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

Physician /Medical Examiner

physician and the burlei-transit The lew requires that the death certificate be executed 080 080

Physician/Medical Examiner þ Completed To the Hospital or Attending Physicien: "
within 24 hours effer deeth.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; p Medical Certification: To Be

20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data XXBurial 2 Cremation 3 Removal from Stata Mount Olivet Cemetery, Sept. 28, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Addrass of Facility. Keeney and Basford P.A. Funeral Home Guo MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Batween Onset and Death Acute pulmonary edema.

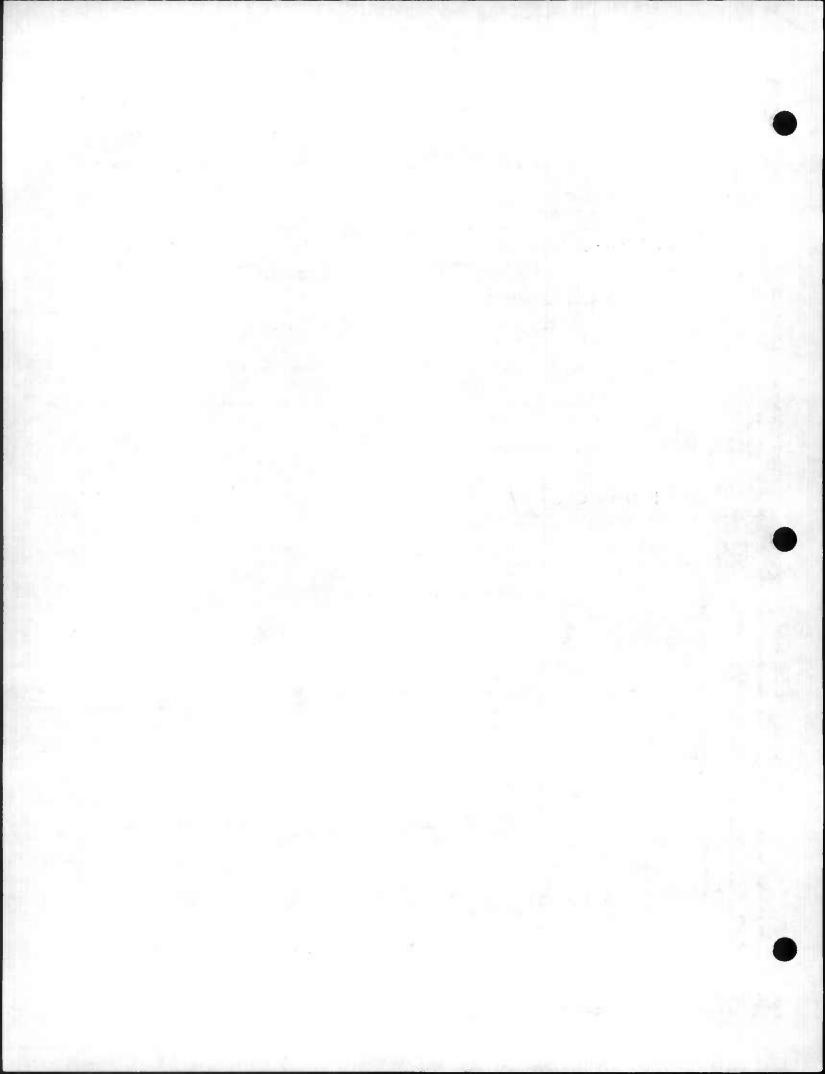
Dua to (or as a consequence of): Immediata Cause (Final disease or condition resulting in death) nour hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated enterts.) that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yea 2 No 3 Probably 4 Unknown alzheimer's dementia 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only ona) 1 ☐ Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier (Check only one) 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

610 Ninth ave

D32073

Brunswick, Hd. 21716

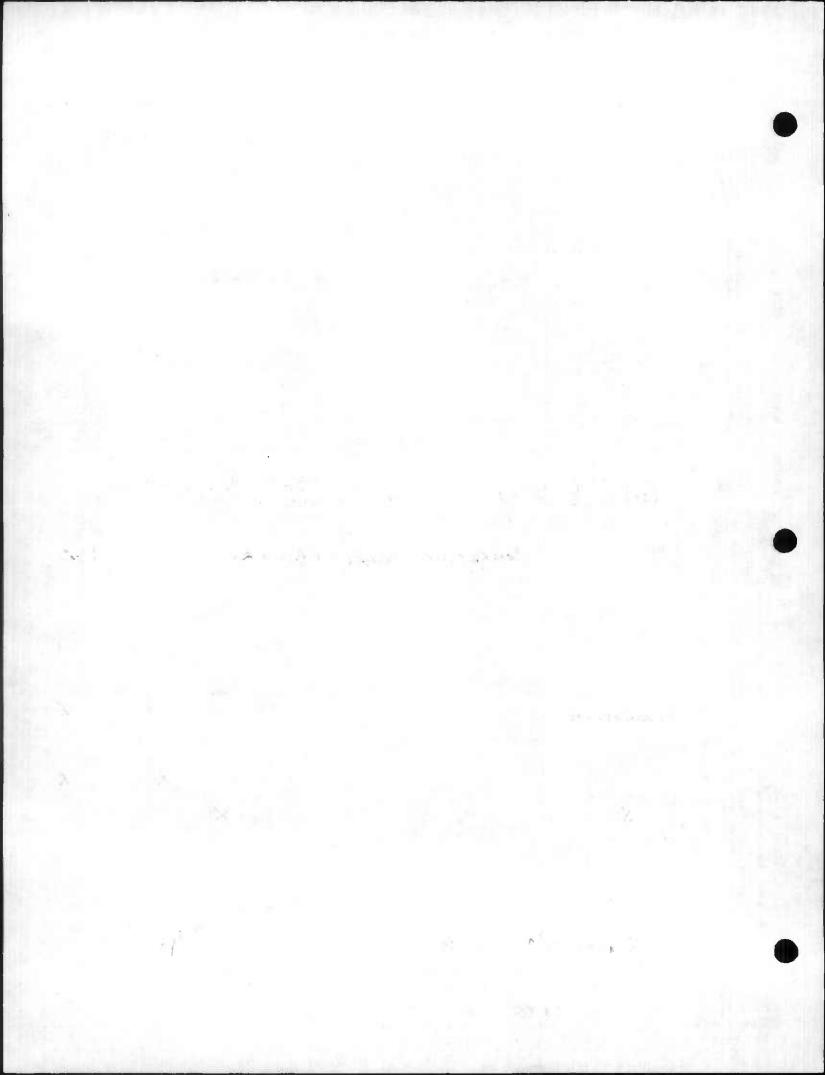


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 9 9 3 | 8 0 |

				Ce	rtifica	te of	Death		Re	g. No.	31	001
Physician	1. Decedent's Neme (First, Middle								2. Date of Death Month	Day	Year	3. Time of Death
/Medical			ark						September	15, 19		10:18 AM
Examiner	4a Facility Name (If not institution 4318 Buckeys								cation of Death	4c. County		
	5. Social Security Number			last birthday)	If Unde	or 1 Year		leric	8. Date of Birth	Fred	lerick	o (Chara or English
Funeral Director	545-34-2863 Usual Residence of Decedent	1□M 2X F	91	Yrs.	Months			Min.	Aug. 31	1908	Country	e (Stete or Foreign
B m	10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10d.	Inside City Limits
or 28s-f sh be notified.	Maryland Frede	erick	Fr	ederic								1 ☐ Yes 2 X No
herrs 23e or 25e-f show ther must be notified at funeral Director	10e. Street and Number 4318 Buckeysto	own Pike				p Code 2170	4		10	g. Citizen of V	-	?
diner must diner must Funeral	11. Marital Status	12. Was Deced	dent Ever in U	J,S. 13.	Was Dec	edent of I	Hispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		e - American k, White, etc	
by by	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced		No No		1□ Yes	_				Specify		
ver then 'netural', it, the Medical Exa Completed by	15. Decedent (Specify only highes			16a. Dece	dent's Us	ual Occur	pation during most	of working	10	6b. Kind of Bu	usiness/Indus	stry
and de	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	use retire	id)					
	17. Father's Neme (First, Middle, I	4		Sch	001	l'eac		r's Nama	(First, Middle, M	Educati		
metic ever To Be	Wilbur	asij	Benw	are				thel			1son	
2 2	19a. Informent's Name/Relationsh Redencion Espir		Giver	19b. Meili			t and Numbe	r or Rura	Route Number, Freder	City or Town,	Stete, Zip Co	
mportant: If Nam 27 ny injury or other ti fice.	20a. Method of Disposition		20h	Place of Disor	eition (No	me of		-	Data 2	0c. Location -	City or Town	, State
lunt or	1 Burial 2 Cremation 4 Donation 5 Other (Sp	ecify)	tate Sm	cemetery, creating								Maryland
any in	21. Signature of Funeral Service L	icensee	MOO2						P.A. Fo			701
sician edical miner	Immediate Cause (Final disease or condition resulting in deeth)	. Con	SESTI Due to (VÆ t	EA-	- - - - - - - - - -	FAI	Lud	26		- 1	YL
physician and s the burist-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a consec	quence of):			717			
ng physicie e as the bu	Cause (Diseese or injury that initiated events resulting in death) Last	c	Due to (or as a consec	quence of)	:		Т		-		
d by the attending pletached for use as the Physician/Med		0										
detached detached	Part II. Other significant condition	ns contributing to dea	ith but not res	sulting in the u	nderlying	cause gi	ven in Part I.					ne cause of death?
igned by be detact	DEMENT 4								1 🗆 Ye	2 □ No	3 Probab	bly 4 Unknow
should should									24a. Was an perform	autopsy ed?	availe	autopsy lindings able prior to eletion of cause
page 2									1 ☐ Yes	2 No	1 🗆 Y	4
certificate rector, par Be Co	25. Was case referred to medical examiner?						28. Place	of Deeth	(Check only one)		
this ce al dire	1 ☐ Yes 2 No	Hospital: 1 □ In	patient 2	ER/Outpatier		UA		rsing Hor	ne 5 Resider	ice 8 🗆 Oth	er (Specify)	
the rue	27. Manner of Death 1 Manual 5 Pending 2 Accident investig		Injury , Day Year)	28b. Time of Injury	f M	28c. Inju Wo 1 □	nyat ork?]Yes 2∐!		8d. Describe how	v injury occur	red	
by th	3 Suicide 6 Could n 4 Homicide determine	ned 289. Place C	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, str	reet, facto	ry, office		2	8f. Location (Str. City or Town,		er or Rural F	loute Number,
Q 2 2		Physician: To the b										
Funeral Di etely filled in dical Cer		xaminer: On the bas										
ompletely filled in	(Check only 2 Medical E	xaminer: On the bas and manne	er stated.			c. Licen:	se number		29	d. Dete signe	d (Month, Da	y, Year)
To the Funeral Di completely filled in Medical Cer	(Check only 2 Medical E	examiner: On the bas and manne	n 2		29		se number			d. Dete signe Septemi		
he Funeral pletely fille edical C	(Check only 2 Medicat E	cho completed cause	n 2 of death (Ite	m 23a) (Type,	Print)	D2	1936	Trodo		Septemi	ber 15	, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death September 04, 1999 3:50 PM Davis Grace Elizabeth 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick If Under 24 Hrs. Frederick If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2\ F Yrs. 212-50-8004 Nov. 17, 1899 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No Maryland Frederick Frederick 10e. Sfreef and Number 10f. Zip Code 10c. Citizen of What Country? 21701 243 West 5th Street 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give X Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 self seamstress 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Calvin Lambert Alice Batson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Alice Marks, daughter 1001 Carroll Parkway, Apt 120, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 9/8/99 Frederick, Maryland 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Keeney and Basford Funeral Home MO0999 106 East Church Street, Frederick, MD 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, onheert failure. List only one cause an each line. Approximete Interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) 12" INTERPRIAL HEMORINAS ? Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f

there 23s or the must be a ò

8

hours after

Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene.

7 is marked other traumatic event,

Department of Health a important: If them 27 is any injury or other tra

Baltimore, Maryland 21215-0020

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Funeral

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Completed

Be 2

 Mospital or Attending Physician: The law requires that the death certificate be executed
2 A bours alterd death.
 Puneral Director: After this cartificate has been signed by the attending physician and
inlessy filled in by the funeral director, page 2 should be detached for use as the burlansif P.O. Box 68760. Division of Vitai Records.

Physician/Medical Examiner

p

Completed

Be

Medical Certification: To

29b. Signature and fitle of certifier

Pert II. Other algnificant conditions of	confributing to death but not re-	sulting in the underly	ing caus	e given in Pert t.	23b. Did tobecco use co	ontribute to the cause of death? 3 Probably 4 Unknown
<u> </u>					24e. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Wes case referred to medical				26. Place of De	ath (Check only one)	
examiner? 1 Yes 252No	Hospitel: 15 Inpatient 2	ER/Outpatient 3	DOA	Other: 4 Nursing		ner (Specify)
7. Menner of Death 1 Netural 5 Pending 2 Accident investigation		28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 Sulcide 6 Could not b			ctory, of	Mice	28f. Location (Street and Num. City or Town, State)	ber or Rural Route Number,
					e, and due to the cause(s) and murred et the time, date end place,	

State Registrar

completely within 2 To the I ŝ

> 198 Valamanchili MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

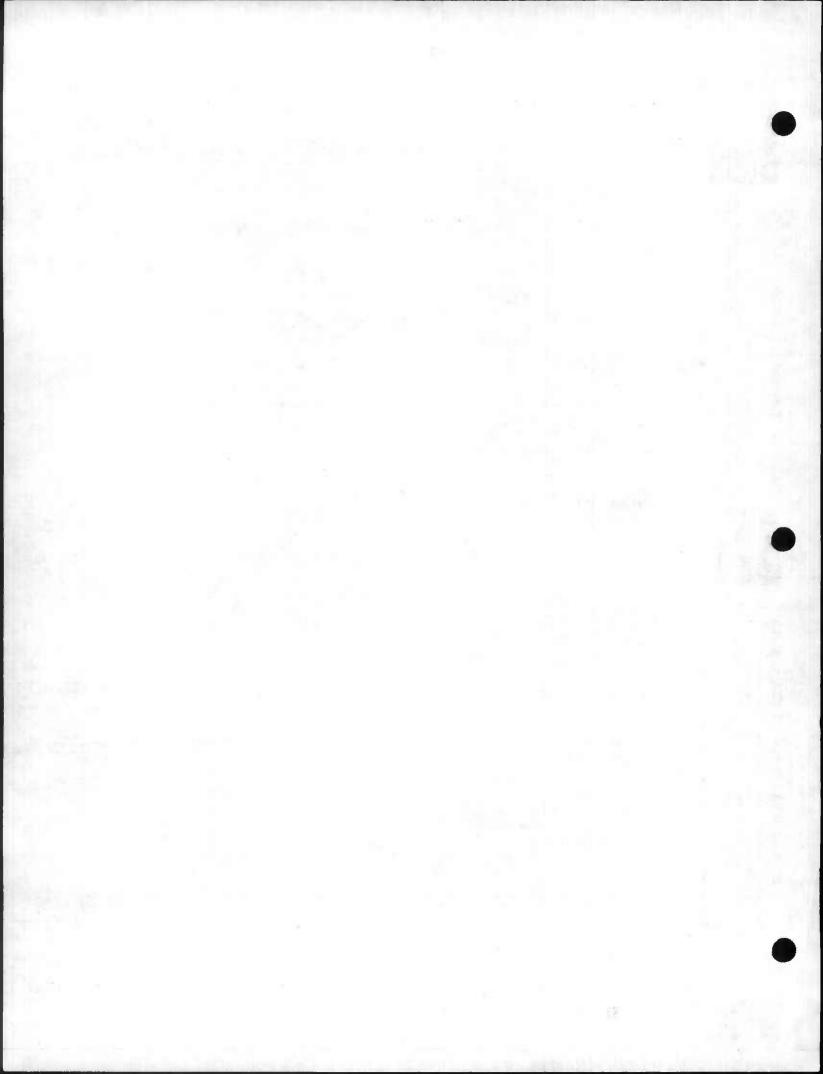


Johnson Drive, #6, Frederick, MD 21702

29c. License number

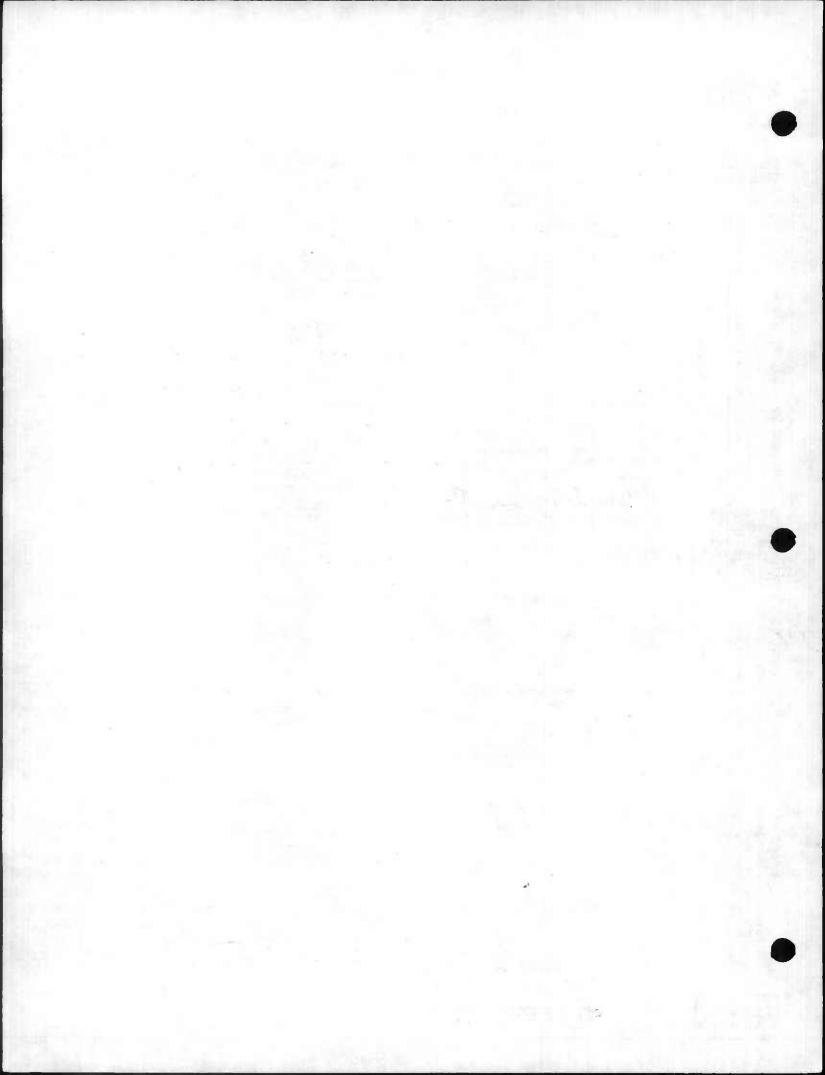
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29d. Dete signed (Month, Day, Year)



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		State of Maryland					rtificate of		Reg. No.					
Physician		1. Decedent's Name (First, Middla, Last)					Control of College (Control of Control of Co			ath Day	Year	3. Time of Death		
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Funeral		5. Social Security Nu			Age (In yrs. las	t birthday)	If Under 1 Year		8. Date of Bir	th .	9. Birthp	lace (Stata or Foraign		
Director		5. Social Security Number 214-10-6649 Output 12 M 2 F 7. Age (In yrs. last birthday) 90 Yrs. 13 Months 14 Under 1 Year 15 Under 1 Year 16 Under 24 Hrs. 16 Under 24 Hrs. 17 Under 1 Year 18 Under 24 Hrs. 18 Days 19 Hours 10 / 28 / 1908 10 / 28 / 1908							Ma	ryland				
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	吉	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									try?			
		8509 Pitt	sville R	load			2	1850		Unite	s Sta	tes		
9 65	Funeral	11. Marital Status		12. Was Decede Armed Force	ent Ever in U,S.	13.	Was Decedent of	Hispanic Origin? (Span, Mexican, Puart	pecity Yes or No		ce - Americ			
21215-0020 d within 72 hours efter giene. The Wedical Exempo the Wedical Exempo	To Be Completed by Fu	. C			Yes 2 🔯 No as, Give ar or Datas:		1□Yas 2⊠ No		The state of the s		Specify: White			
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Parte at		4 Donation 5 Other (Specify) Damascus Methodist Cemetery 9/13 Damascus, Maryland 21. Signature of Euneral Service Licensee 22. Nama and Addrass of Facility												
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Division of Vital Re To the Heaptal or Atlanding Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s)												
the pie	Med	one) and manner stated.												
5 × 5 %		29b. Signature and title of certifier 29d. Date signed (Minth, Day, Year)									2			
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		30, Name and address	syll person who	completed cause of	death (item 2	a) (Type,	Print)	011	/		1			
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State of Maryland / Department of Health and Mental Hygiene Q Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** Rena M. Dorrell 4:00A.M. September 20, 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8600 Pinecliff Drive Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
March 28,1917

South Dakota 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 KF Yrs. 209-20-4969 82 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 ☐ No Directo 25a-f 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ma 23a or 8600 Pinecliff Drive 21704 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck White etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 about be in ment of Health and Mental H ant: If them 27 is marked off jury or other traumatic even å Almer Mc Cordic Margaret Piper 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2550 North Granada, Arlington, Virginia 22207 Kate Dorrell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/24/99 Hagerstown Crematory Hagerstown, Maryland 22 Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Fike Frederick, Maryland 21702 21. Signeture of Funeral Service Licenses ene Maron (anulle 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart leiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finat . DIOPATHIC HYPERTROPHIC SUBADRIC STENOSIS disease or condition resulting in death) Examiner Due to (or as e consequence of): Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): physician the buria Box 68760. Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? P.O. signed by t 1 ☐ Yea 2 No 3 ☐ Probably 4 ☐ Unknown CHRONIC PLEURAL EFFUSION. Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed CANCER WITH METASTAGLS page 2 1 Yes 2 No 1 ☐ Yes 280 No Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Cartifier edical (Check only within 2 \$ the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sex 1) 21936 and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK NO # 100 DR DONALSON 170 THOMAS UDITH SON 31. Date filed (Month, Day, Year) 2 3 1999 32. Registrar' Signature State

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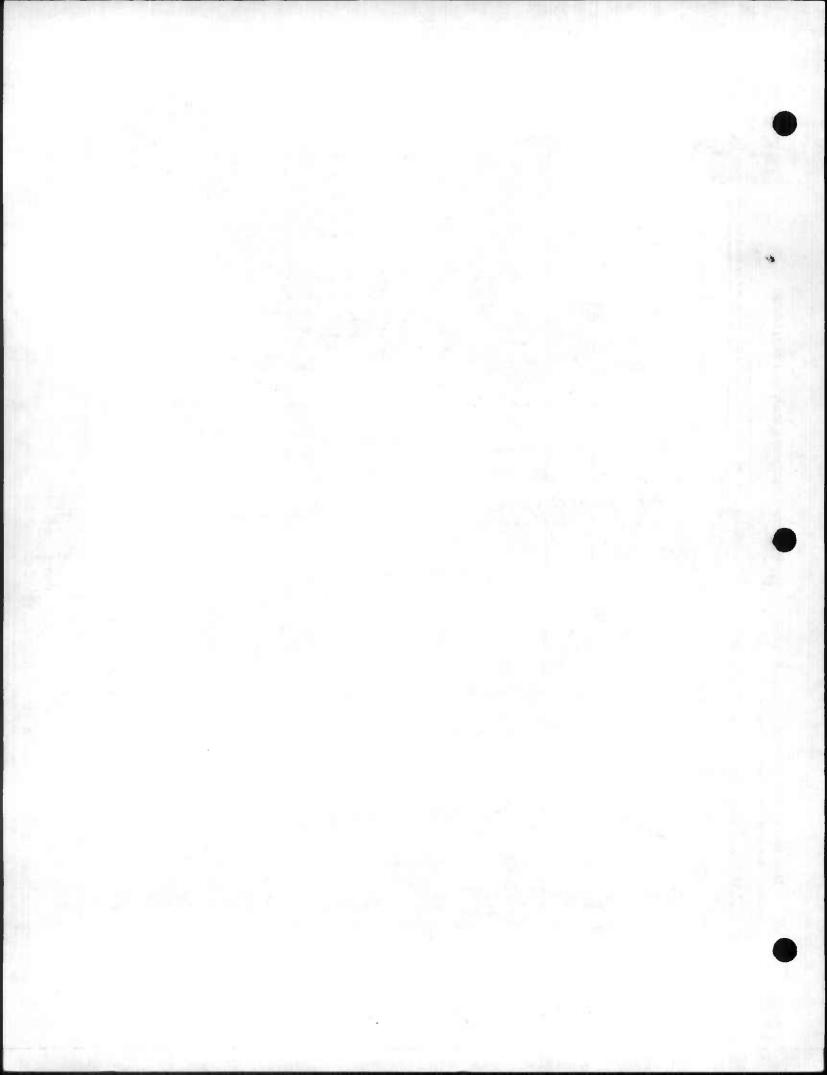
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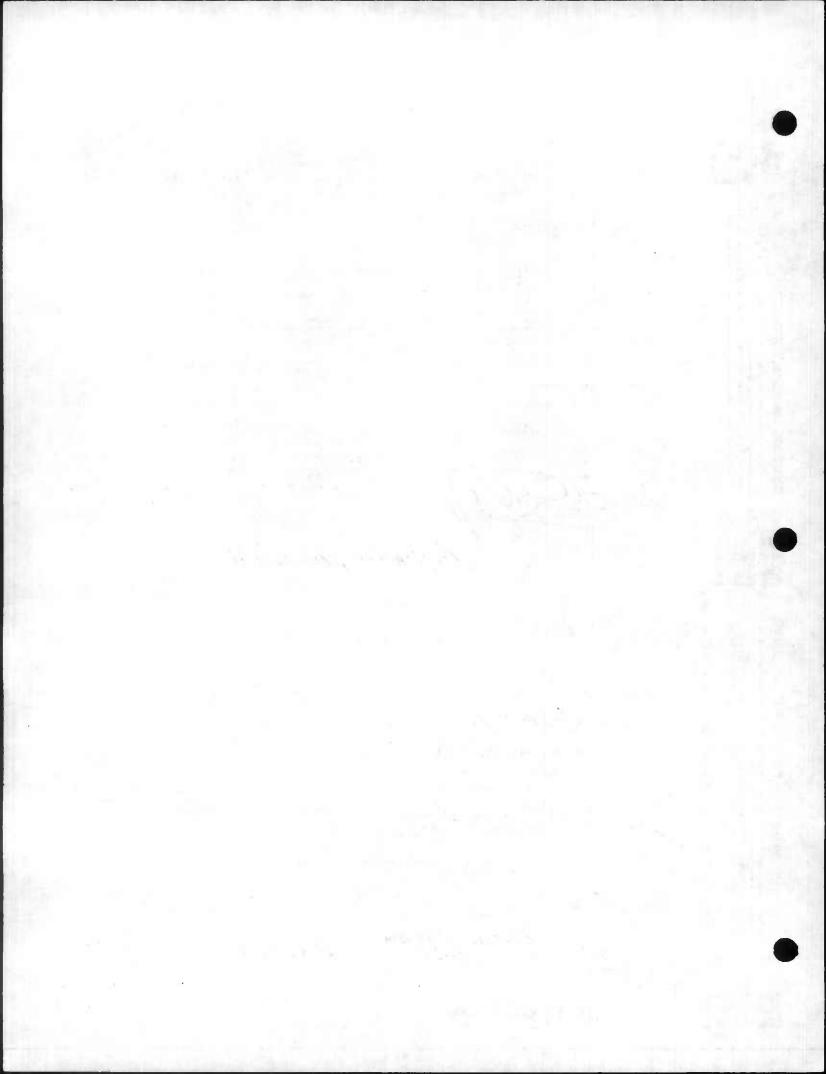
State of Maryland / Department of Health and Mental Hygiene 9 9 3 | 8 0

			Certific	ate of Death	Re	g. No.	318	U5			
Discolation	1. Decedent's Name (First, Middle, Las	t)		2. Date of Death Month Day Year 3. Time of Death							
Physician /Medical	Dorothy Mae	Davis			Septembe	r 22,1	999 3:	55 pm			
Examiner	4a Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	4c. County	of Death				
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uneral irector	214-34-2327	T370 -		Months Dave Hours Min (Month Day Year) Country							
	Usual Residence of Decedent 10a. State 10b. County	10c Cit	ty, Town or Location				10d Insi	de City Limits			
Director	Maryland Frederi		rederick								
d a	502 Trail Avenue			10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A.							
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		cedent of Hispanic Origin? specify Cuban, Mexican, Pusts 2 No Specify:	(Specify Yes or No- erto Rican, etc.)		a - American India ck, White, etc.				
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	Mrs. Alta Toms /		7295-C C	Coachlight Ct	4	-	yland 21 City or Town, Sta				
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State P16	cemetery, crematory	or other place) 1 Cemetery S							
8000	21. Signature of Funeral Service Oceansee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701										
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of			node of dying, such as cardi	iac or respiratory arre	st,	Appro	ximate at Between			
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c	MBST63 V	ne lives			20	yeur			
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0	everniner?	Hospital:	26. Place of Death (Check only one) 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 8 \(\text{Other} \) (Specify)								
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led in by the funeral Certification:	1 🖾 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	(Month, Day Year) 28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fac								
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pletaly fi	and manner stated.										
E 2	29b. Signature and title of certifier	7 /		29c. License number 29d. D				Pate signed (Month, Dey, Year)			
	Mak A /4	1- MD		129591		9/23/99					
	30. Name and address of person who o	ompleted cause of death (Iten	m 23a) (Type, Print)	1)		-	^				
	MARK P. RUD	IN 201 Th	romas Jul	min in	Frenerick	My	0 217	02			
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State of Maryland / Department of Health and Mental Hygiene 9 9 3 | 8 |

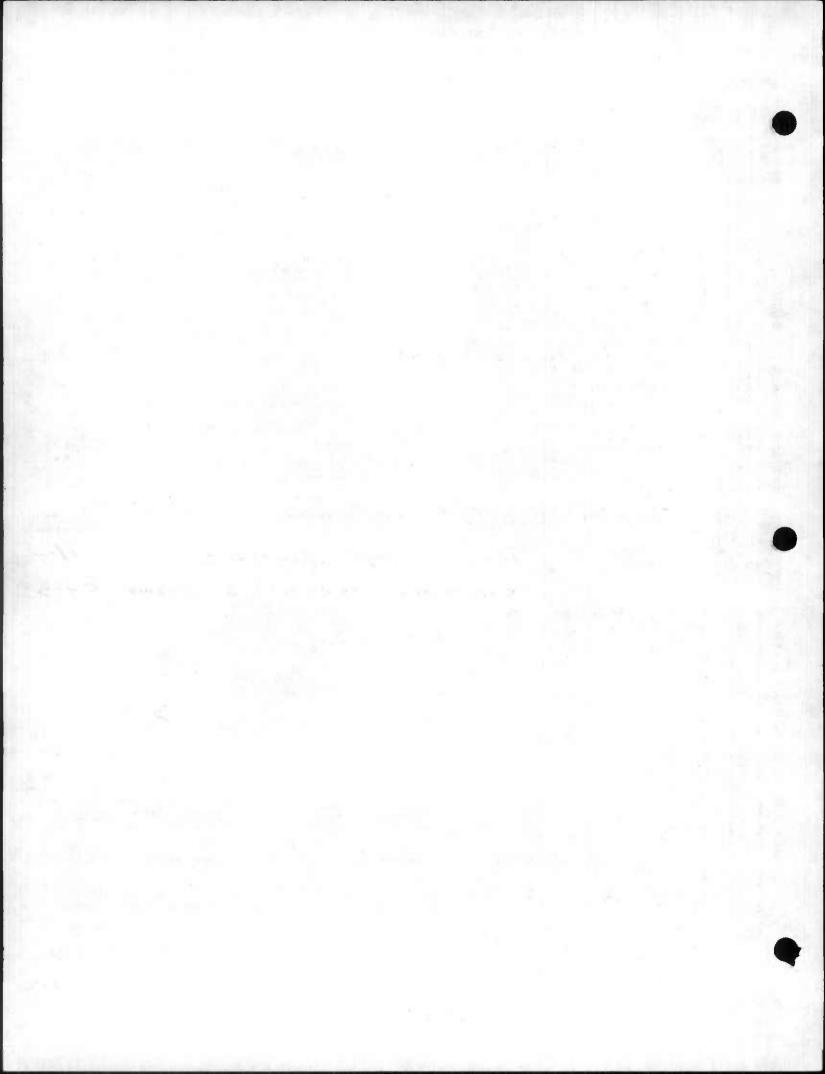
	Certificate of Death Reg. No.											
	1. Decedent'a Neme (First, Middle, Last				2. Dete of Dea	3. Time of Death						
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2	Frederick Memoria	Frederic	ck Frederick									
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or 28a4 s be notified Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?											
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the mo	Comonally Colonially (C 12)	5+	Military					U.S.				
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To	William Homer Eato	on				Olga Vie	eweger					
1	19a. Informent's Neme/Reletionship (T)	ype, Print)	19b.	Mailing Address	(Street	and Number or Ru	ral Route Number	, City or Town,	Stete, Zip	Code)		
5	Patricia Stevens	(Daughter)	15	Harp P1	lace	, Myersv	ille, Ma	ryland	21773			
or off	20a. Method of Disposition 1 2 Burial 2 Cremetion 3 DF	3	20b. Plece of cemeter	Disposition (Nem y, cremetory or of	ne of ther plec	e)	Dete	20c. Location -	City or Tox	wn, Stete		
70	4 Donetion 5 Other (Specify)		Arling	ton Nat.	Cei	metery !	9/16	Arlingt	ington, Virginia			
any ing	21. Signature of Ponetal Service Ligard	Da Out	1	ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701						P.A.		
	23a. Part1. Enter the disease, or complete shock, or least failure. List only or	lications that call and t	hedeeth. Do r						PID Z	Approximete		
the burial-transit	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events		e consequence of):									
	resuring in death) Last	C										
d for use	Part II. Other significant conditions co.	ributing to death but not resulting in the underlying cause given in Pert t.					23b. Did to	23b. Did tobacco use contribute to the cause of death?				
y Physician/N	A	riot resulting in	and underlying de	use giv	on arr on c.		1 Yes 2 No 3 Probably 4 Unknown					
eted b	(A)	Shouldes	fx				24a. Wes a perfor		cor	ore autopsy findings allable prior to appletion of cause death?		
page 2 Comp		`					1 🗆 Y	es 2 No	10	Yes 22 No		
ractor, page Be Co	25. Wes case referred to medical					26. Place of Dee	th (Check only or	19)	1			
. = 0	examiner?	Hospitel:	2 ERVOU	tpatient 3 DO	A Oth	00	ursing Home 5 Residence 6 Other (Specify)					
œ ·	27. Manner of Death	28a. Dete of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								,		
at o	Netural 5 Pending investigation	The second secon										
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	y - At home, fer (Specify)	ne, ferm, street, factory, office 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)									
completely filled in by the funer Medical Certification:	29a. Certifler (Check only one) Certiflying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner es steted.											
M M	29b. Signature end title of certifier 29c. License number 29d. Date signed (Marritt, Play, Year)									Yay, Year)		
	12 Edward / normeson 029262 9/4/							14/4	1			
133	30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)											
	Edward Thompson, A	•			tal.	W. 7th	St. Fr	ederick	, MD	21701		
State	31. Date filed (Month, Day, Year)	32. Registraç					.,		,			
Decistor	CED A O		Elmer .	19								



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** Sarah Lee Eyler September 13 1999 6:15 A.M. /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 505 Taney Avenue Frederick
If Under 24 Hrs. Frederick If Under 1 Year Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Date of Birth (Month, Dey, Year) **Funeral** Days 1□M 2\ F Yrs 219-14-8430 Director July 18, Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow WYes 2□No Directo Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 505 Taney Avenue 21702 United States deeth Funerai 12. Wes Decadant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indien, Black, Whita, etc. 11. Meritel Stetus permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or fler any injury or other traumatic evant, the Medical Example 2005. 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Federal Government Laboratory Technician 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meiden Surname) Be Henry Grover Grandy 0 Mary Alma Butler 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Walter Castle Eyler, Husband 505 Taney Avenue Frederick, Maryland 21702 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata XXBurial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Olivet Cemetery 9/16/99 | Frederick, Maryland 22. Nama and Addrass of Facility Stauffer Funeral Homes, P.A. 21. Signeture of Funaral Service bicense 1621 Opossumtown Pike Frederick, Maryland 21702 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Finel disaasa or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner 000 775168 that the death certificate be axecuted attending physician and for use as the burial-transit Sequentially list conditions, if any, laeding to immadiate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Dua to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Records. þ e Hospital or Attending Physician: The law requires 1 2.4 hours after deeth. • Euroral Director: After this cardificate has been signi leiely filled in by the funeral director, page 2 should be Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 🗆 Yas 1 ☐ Yas 2 ☐ No Division of Vitai Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Sulcida 6 Could not be 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) pletely filled in by 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) end manner as stated.

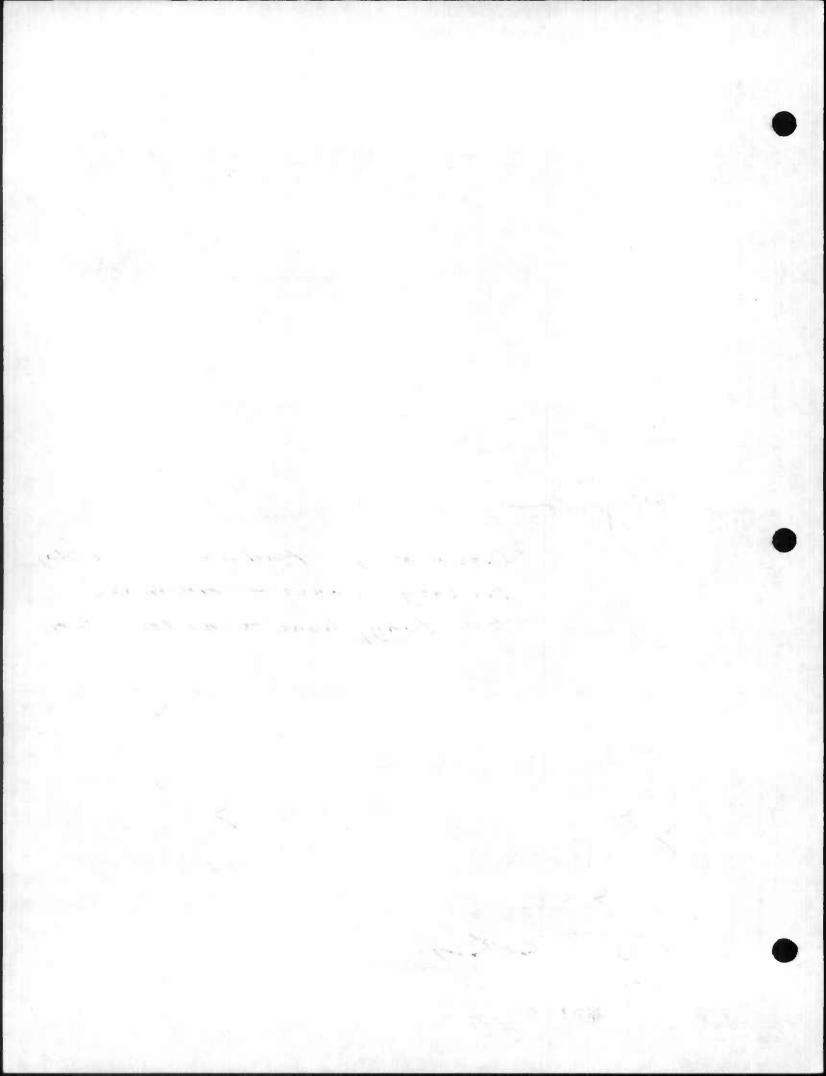
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I complet 205 Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26 146 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) 40364 501 31. Date filed (Month, Day, Year) 32. Registra/s Signature State 1 4 1999 ▶ SEP Registrar

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ysician ledical aminer	1. Decedent's Nen				06	erunca	te of	Death	1	Reg. No. 2	J J	1808
	Буп	ne	Wallac	ce	E	tchis	on		2. Dele of D Septem	ber ^{Da} 26,1	999	3. Time of Death 12:15pm
	4e Fecility Neme (imber)					r Location of Dea derick		of Death deric	k
eral ctor	5. Social Security I 143-26-	8845	6. Sex 1 □ M 2 1 F	7. Age (In yrs.		Month:	or 1 Year Days	If Under 24 H		hith Year) 5, 1932	9. Birthpi Count New	ace (State or Foreign Ty). Jersey
tor	Usuat Residence of 10a. Stete Maryland	10b. County Frede	rick	10c. Cit	reder:	ocation ick					10	Od. Inside City Limits
Funeral Director	10e. Street and Nu 1206 Pi	mber newood	Drive			10f. Z	ip Code	21701		10g. Citizen of V		try?
by	11. Meritel Status 1 Never Men	ried 2 Merrie	Armed F	2₫No ive	,S. 13	Wes Dec If Yes, sp		lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	Yes or No- n, etc.) 14. Race - American Indien, Black, White, etc. Specify: White		
S CO		15. Decedent's city only highest ondery (0-12)	grade completed)	1-4or 5+)	(Giv	edent's Us re kind of w DO NOT Homen	ork done use retired	<i>during</i> most of w d)	orking 16b. Kind of B		Business/Industry Own Home	
To Be Co	17. Father's Name Titus		ast) Hinsly	-	Irons			18. Mother's N Helen		e, Maiden Suman Mi	tchel	.1
_	19e. Informent's N Meredith	leme/Reletionsh Page E	ip (Type, Print) tchison/	Daughte	19b. Mai 439	ling Addre	ss (Street	and Number or I	Aural Route Num	ber, City or Town, ton, Ken	State, Zip LTUCKY	Code) 7 40517
			3 □Removel from	State	Plece of Disponentery, con Olive	emetory or	other pled	y Sep	Date 29, 1999	20c. Location - Frederi	•	
	21. Signature of F		**	MOO						uneral H rederick		21 701
edical Examiner	Immediate Cause disease or condition resulting in deeth) Sequentially list or if any, leeding to incause. Enter Und Cause, (Disease or Understein Cause, (Disease or Understein Cause)	on .		Due to (c				for acz onz	- m	ectustical codes	~ ()	2 27
lan/Medical	thal initialed event resulting in death)	5	d	Due to (o	r es a conse	equerice/of):				1	
by Physician/M	Part II. Other signi	ficant condition	s contributing to d	eath but not res	ulting In the	underlying	cause giv	ren in Pert t.		Yes 2 No		the cause of death
Completed										s an autopsy formed?	ave	ra autopsy tindings vilable prior to npletion of cause death?
Be Con	25. Was case rete	rred to medical						26 Place of D	1 C	Yes 20No	10	Yes 2□ No
To E	examiner?	No	Hospital:	tnpatient 2	ER/Outpatio	ent 3 🗆 🛭	Oth Oth			sidence 8 Oth	er (Specif))
Certification:	27. Manner of Deal 1 Deaturel 2 Accident 3 Suicide	th 5 Pending investigs 6 Could no	ation at he	oth, Day Year)	28b. Time Injury	М		yat k? Yes 2⊡No		how injury occur		10 to North
	4 🗆 Homicide	determin	build	e of Injury - At he ing, etc. (Specif	y)				City or To	(Street and Numbown, Stete)		
Medical Certificat	29a. Certifier (Check only one)	2 Medical E	Physician: To the band man	e best of my kno easis of examine oner steted.	wiedge, dea tion and/or i	nvestigatio	n, in my o	ne, date end pla pinion, death oc	ce, end due to the curred et the time	e cause(s) and mo o, date and plece,	and due to	the cause(s)
ž	29b. Signature and	title of certifier		/		2		e number 4626		29d. Dete signe September		
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State of Maryland / Department of Health and Mental Hygiene Q Q

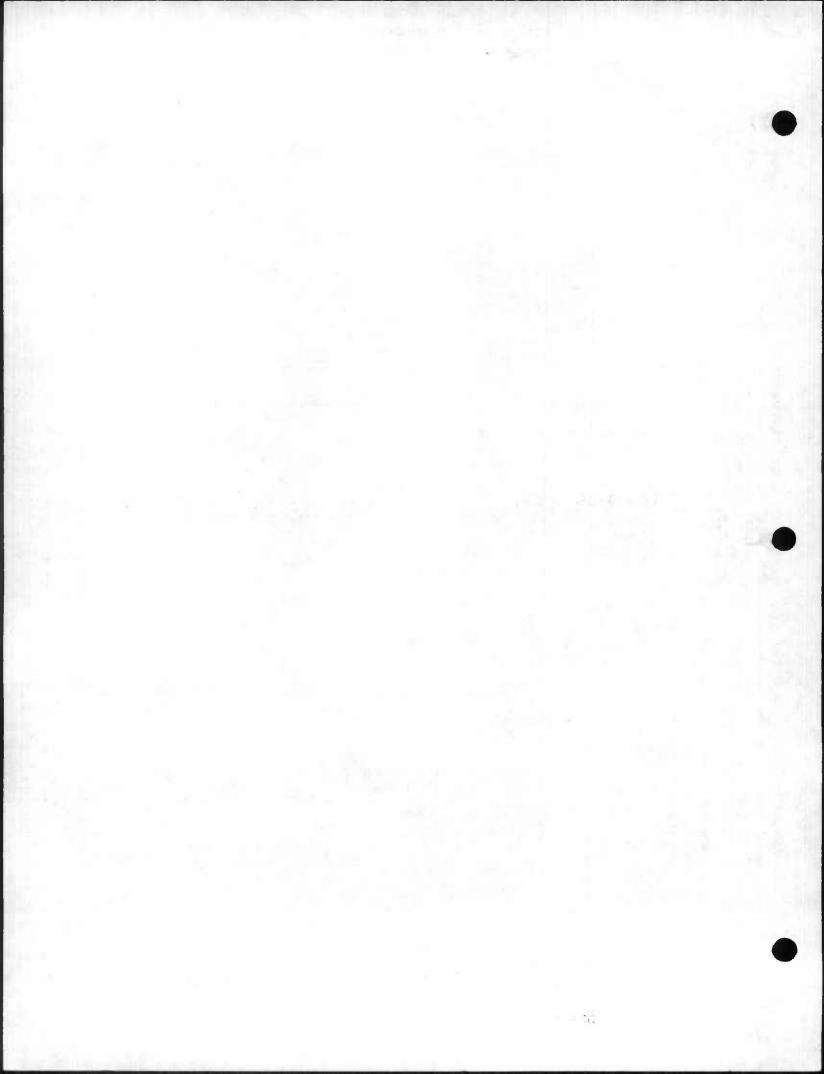
3 1 8 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death August 30, 1999 **Physician** Glendora Lee FLANAGAN 7:10 PM /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1709 Rosemont Avenue Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
July 13, 1924 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 235-34-6259 1 M 2 X F 75 Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f short the Medical Examiner must be notified at West Virginia Tucker Parsons 1 XYes 2 No Director 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after deeth with nent of Health and Mental Hygiens. Interfer them 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Market Exemples. 103 Chestnut St., Apt. 115 26287 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes XXNo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 Married
Widowed 4 Divorced Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: White à Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be CONNEWAY Richard LILLER Mabel 19e. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Hilda Marusiodis, Daughter 1709 Rosemont Ave., Frederick, Md. 21702 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny injury or once. Parsons City Cemetery, Sept. 2, 1999 Parsons, West Virginia 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Keeney and Basford P.A. Funeral Home MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21701 Approximate triterval Between Onset and Death **Physician** 8 month Immediate Ceuse (Finet disease or condition resulting in death) /Medical Endometrial Cancer Examiner Due to (or as a consequence of) Examiner iclan and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequenca of): 88 use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No Hypertension þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Where (Specify) Daughter's Certification: To 1 ☐ Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending n 24 hours after deeth.

The Funeral Director: After the funeral in by the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral in the funeral interests. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Combine Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my solidar, death occurred. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi hiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number August 31, 1999 D 51643 30. Nama and addrass of person who campleted cause of death (ttem 23a) (Type, Print) 170 Thomas Johnson Drive, Suite 100, Frederick, Md. 21702 Shah MD Hiren N. 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar **92** 1999 Aparta

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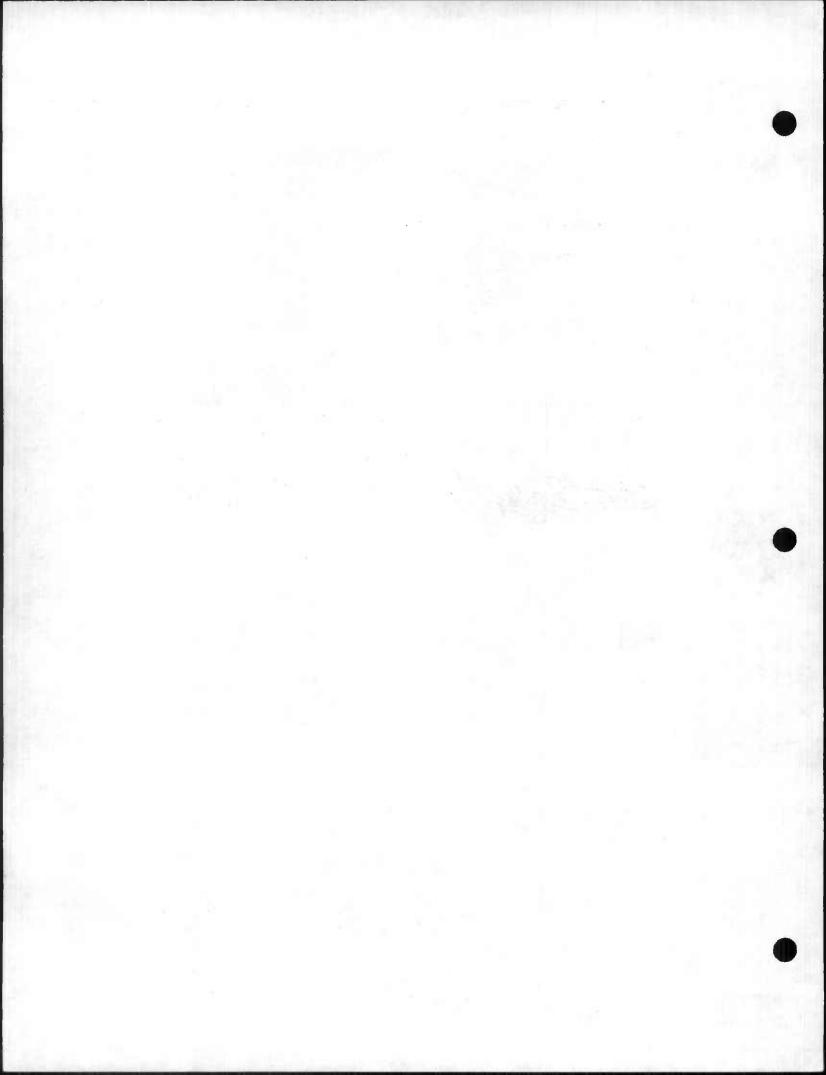
State of Maryland / Department of Health and Mental Hygiene

99 31810

						Cei	rtificate of	Death			Reg. No.		01010
	Physic		Decedent's Nama (First, Middla, L.)	Sereta Webb	F1	ynn				2. Data of De Month Septemb	ath Day	Yaar	3. Time of Death 6:40 PM
	/Medi		4e. Facility Nama (If not institution, g					4b. City. To	own, or Lo	ocation of Death			
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⊢	-	_					If Under 1 Yaa		kvil	_		ontgo	
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	pus *		Usual Rasidance of Dacedent 10a, Stata 10b, County	100	City, Tow	m or Lo	cation						10d. Inside City Limits
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	deep en en	Jer	11. Maritel Stetus	12. Wes Decedant Evar in	U,S.	13. \	Wes Decedent of If Yes, specify Cu		igin? (Spe	ecify Yas or No			Ican Indien,
	fler free	Funeral	1 ☐ Nevar Married 2 ☑ Married	Armed Forcas? 1 ☐ Yas 2 ☑ No		1	f Yes, specify Cu	ben, Maxica	n, Puarto	Rican, atc.)	Bla	ck, Whita,	, atc.
22	permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at ODGe.	þ	3 ☐ Widowad 4 ☐ Divorced	If Yas, Giva Yeer or Datas:		'	1 ☐ Yas 2 🔀 No	Specify:			Specif	y: Wh	ite
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$\frac{8}{2}$	Men	ို	Denver Webb					Beul	ah C	hurch			
a	and and		19a. Informant's Neme/Ralationship	(Type, Print)	198	o. Meilin	ng Address (Stree	et and Numb	er or Rure	al Routa Numbe	er, City or Town	, Steta, Zi	p Coda)
	alth a		Edward J. Flynn/	Husband	2	6250	Purdum	Road.	Dam	ascus.	Marylar	nd 2	0872
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	m		shock, or heart failure. List onl	y ona cause on thich lina.							1000		Intarval Batwean Onset and Death
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	Examiner		diseasa or condition rasulting in death)		14	IM	1 CM	TUR					4.5 YEM?
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o.	the de	sic	Part II. Other significant conditiona	contributing to death but not r	asulting I	n tha ur	ndarlying causa g	ivan in Part	t.	23b. Did 1	tobacco use co	ntributa t	to the causa of death?
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Records,	v require been sign should t										an autopsy		Vara autopsy findings
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VITAI	Physician: The rthis certificeta	Be	25. Was casa rafarred to medical axaminar?					26. Plece	of Daath	h (Check only c	ne)		
	ysic is ce dire	2	1 Yas 2 No	Hospital: 1 ☐ Inpatiant 2	□ ER/O	utpatian	t 3 DOA	ther: 4 No	ursing Ho	me 5 Rasio	tanca 6 Ott	ner (Speci	(y) Hospice
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UNISION	I or Attending after death. Director: After d in by the funa	Certification:	3 ☐ Suicida 6 ☐ Could not	28a. Placa of Injury - At	homa fa	arm stra	aat factory office			28f. Location (S	Streat and Num	ber or Rur	ral Route Number,
$\frac{2}{5}$	or after Dire	T	4 ☐ Homicide datarmine	building, atc. (Spe	cify)	arrit, otto	aat, taotory, omoc			City or Tov			ar rivate rivation;
-	To the Hospital or I within 24 hours after To the Funeral Direct Completely filled in b								, ,				
	t ho	edicai	29a. Cartifier Cartifying P	hyelctan: To the best of my k minar: On the besis of axami	nowladge	a, daath	occurred at tha t	ima, data an	nd placa, a	and due to tha	causa(s) and m	annar as s	stated.
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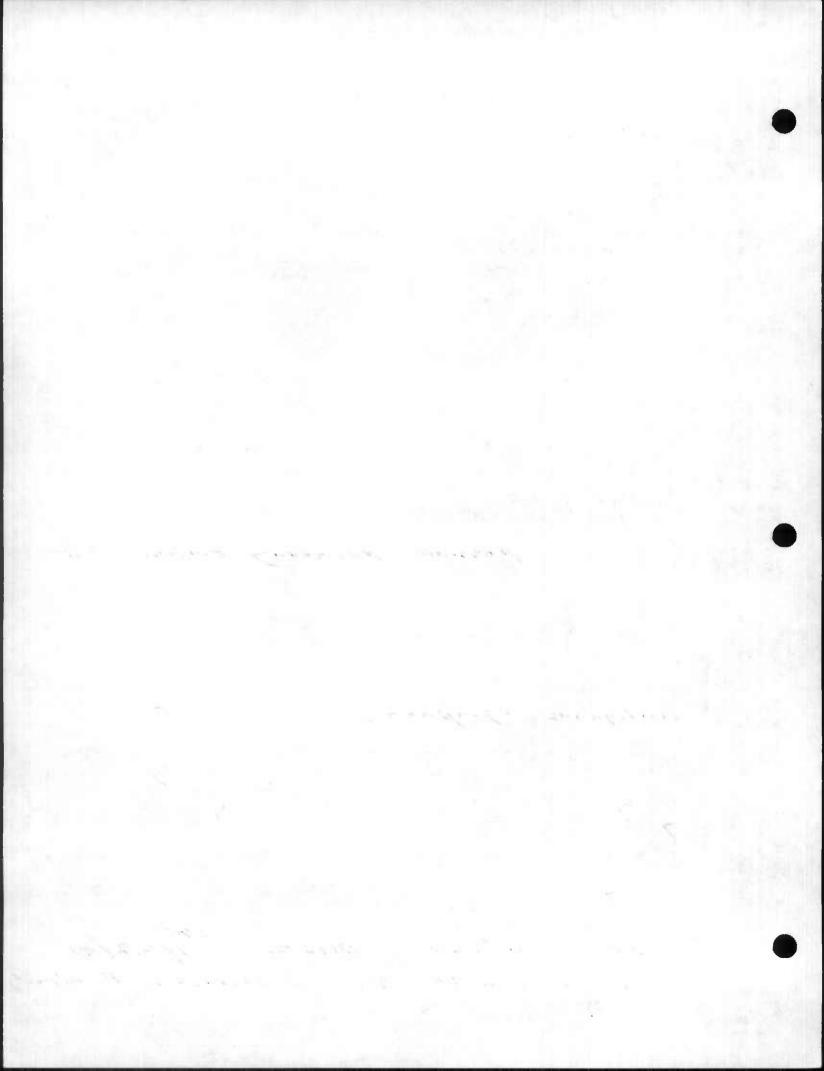
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State of Maryland / Department of Health and Mental Hygiene

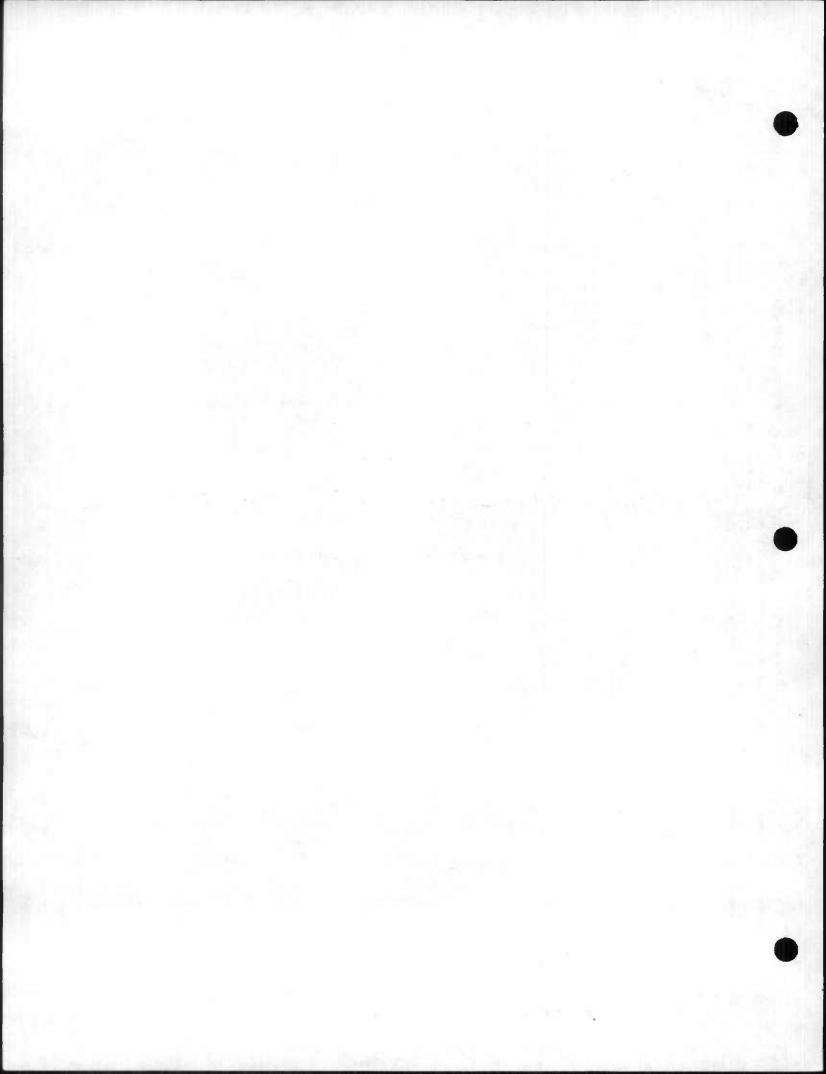
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To E	Erik Frankl	in F	oland			Elizabe	1			ıpman	
,	19a. Informant's Name/Reletionship (Erik F. Foland)				,		rederick,				
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Ž	29b. Signatura and title of certifier	10		29c. License number 29d. Dete signed (Month							
	30. Nama and addrass of person who	Has Z	eth (Item 23a)	(Type, Print)	D00	46074	S	Septembe	r 25,	, 1999	
	Jana S. Hash, 1				Free	derick	Mary land	21702			
State	31. Deta filed (Month, Day, Year)	32. Registrar		and cride ,	4	/	arry rente	21/02			
-Augu	SED 7	2 1000 A	A Proposition of the Party of t	- 4	/	1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Month Vaar **Physician** Doris Belle **GROSS** September 4, 1999 4:55 P.M. /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick 8. Data of Birth Dec. 31, 1920 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 9. Birthplace (Stata or Foreign **Funeral** Days 1 □ M 2 ☑ F 78 Months Hours Mary land 213-24-8101 Director Usual Rasidance of Decedant permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Haelth and Mental Hygiene. Important: If Itam 27 Is marked other than "naturel", or frems 23a or 28 and 2008. 10a State 10b County 10c. City. Town or Location 10d. inside City Limits Maryland Frederick Frederick 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 200 East 16th Street 21701 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, atc.) 14. Race - Amarican Indien, 11 Marital Status Black, Whita, atc. 1 Yas 2 No 1 Nevar Married 2 Married 1 Yas 2 No Specify: White Specify: by 3 Widowed 4 Divorced Yaer or Detes Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Home Elamantary/Secondary (0-12) Collega (1-4or 5+) Care Giver Health Care 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Leslie Guv Gross Elsie Grace Heffner 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Barbara Grimes/Niece 5928 Quinn Rd., Frederick, Maryland 21701 20h Place of Disposition (Nama of Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Reformed Cemetery 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stata Sept. 8, 1999 Jefferson, Maryland 4 Dopation 5 Other (Spacify) 22. Nama and Addrass of Facility Keeney & Basford Funeral Home M00021 106 East Church Street, Frederick, Md. 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onset end Death **Physician** /Medical immediata Causa (Final CARCINO MATOSIS disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner CARCINOMA FEW MONTHS physician end the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Causa (Disaase or injury that initiated avants rasulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): isigned by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evailable prior to completion of cause of death? been si Completed 24a. Was an autopsy has le 2 s cartificate has director, page 2 1 Yas 2 No 1 □ Vas 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complataly filled in by the funeral director; p Be 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Chack only ona) Other: 42 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mannar of Daath 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant NA 6 Could not be 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifian 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signature and title of cartifiar 29c. Licensa number 29d. Date signed (Month, Day, Year)

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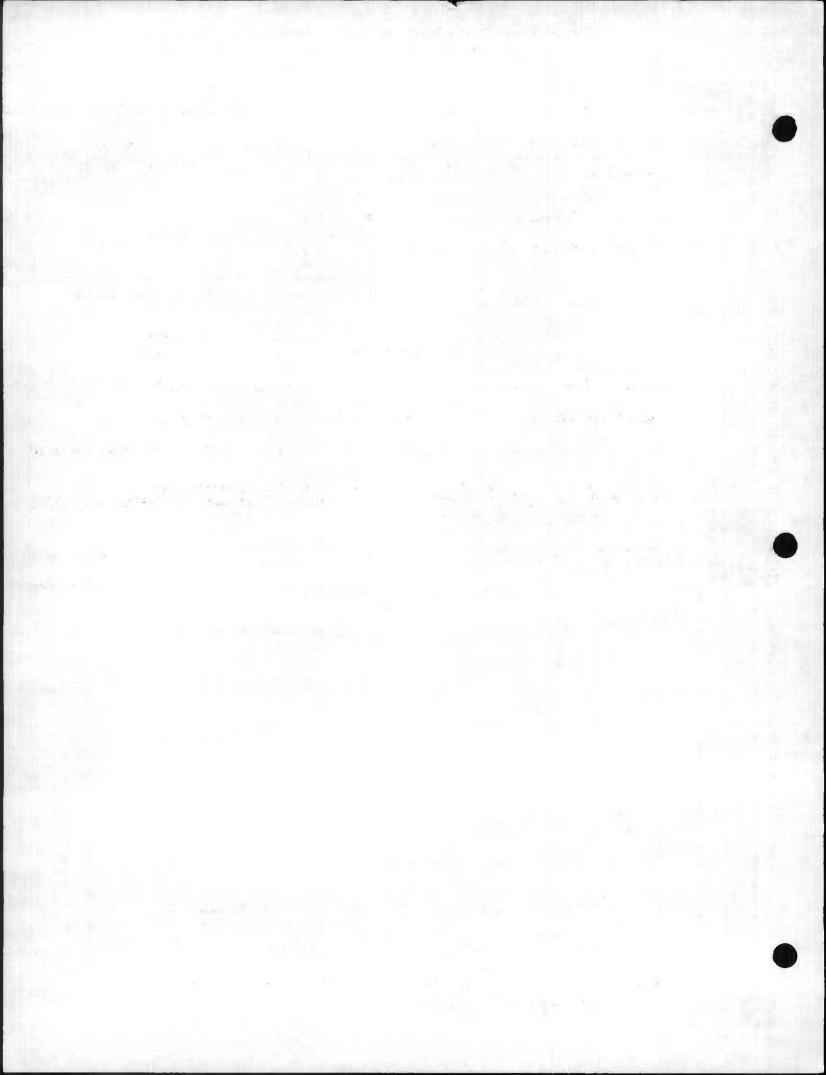
8 1999 Registras Signature

Majeed, M.D., 801 Toll House Ave., Frederick, Maryland 21701

30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Typa, Print)

18063

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Day Year Month Sun Ae Greene September 8, 1999 10:12 PM 4a Facility Neme (If not institution, give street end number) 4b. City. Town. or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Hours 1□M 2QF Yrs. 60 223-98-2462 July 16, 1939 Usual Rasidance of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 □ No Tennessee Carter Roan Mountain 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? Palmer Lane 37687 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ XNo If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Stalus 14. Race - American Indian. Bleck, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify. Korea 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker self 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) unknown unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dalis Greene / husband 755 Palmer Lane, Roan Mountain, TN 37687 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 9/8/99 Hagerstown, Maryland 21. Significa al Euperal S 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Tice Licansee 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pert1. Enter the disease, or complications that caused the deeth shock, or heart feilure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Deeth he Immediate Cause (Final Acidosis disaasa or condition resulting to deeth) Due to (or es e consequence of): 5400 Sequentially list conditions, if any, leeding to immadiele cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in death) Las! Due to (or es e consequence of): 41-70676 5 Ula clauson Dua to (or as a consequenca of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 16 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yas 2 No 1 Yas 2 No 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mennar of Death

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours after

al Hygiene.

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aitimore, Maryland

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ician and buriel-transit 080 signed by the a d be detached f e Certification: To n 24 hours after death.

Ne Funeral Director: After platable filled in by the fun

25. Was case referred to medicat 1 Yes 2 No

1 Neturet

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending

investigation 6 Could not be determined 28e. Date of Injury (Month, Dey Year)

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier

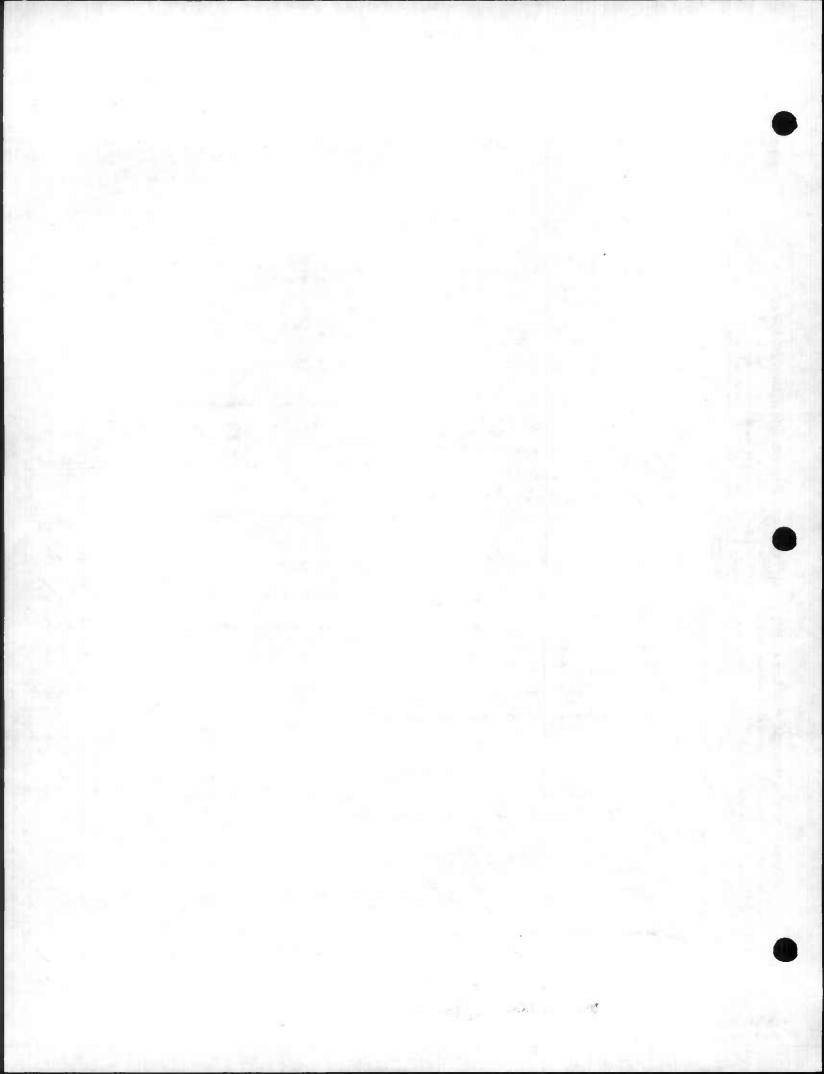
29c. License number D14620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 05 56

State Registrar

edical



Please Type or Print in Black indelible lnk. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death HAROLD WILLIAM **GROVE** SEPTEMBER 12:01 A.M. , 1999 11 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 218-24-2096 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Day, 1928 9. Birthplece (State or Foreign Days 1X M 2□ F Months Hours Maryland Yrs. **Usual Residence of Decedent** 10a. State 10b. Counts 10c. City, Town or Location 10d. Insida City Limits Maryland Frederick Myersville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3901 Crow Rock Road 21773 U.S.A. 12. Wes Decedent Evar in U.S. Armed Forces? 1 X Wes 2 No. 1947–1950 If Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Animal Caretaker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Greenberry Grove Mamie Heffner 19a. Informant's Name/Relationship (Type, Print) Mrs. Clara V. Grove, wife 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3901 Crow Rock Road, Myersville, Maryland 21773 20a. Method of Disposition 1 ☐ Burial 24☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Smithsburg Crematory, Sept. 15, 1999 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Fecility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) Cardiac Death - V. Fib / V. Tach 20min ardiomyopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequ Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown Chronic Renal 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? NIA 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

rai', or hama 23a or 28a-f ehow Examiner must be notified at

pemit. Peges 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or han any injury or other treumatic event, the Medical Examples

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Baltlmore, Maryland

Box 68760.

Division of Vital Records, P.O.

Director

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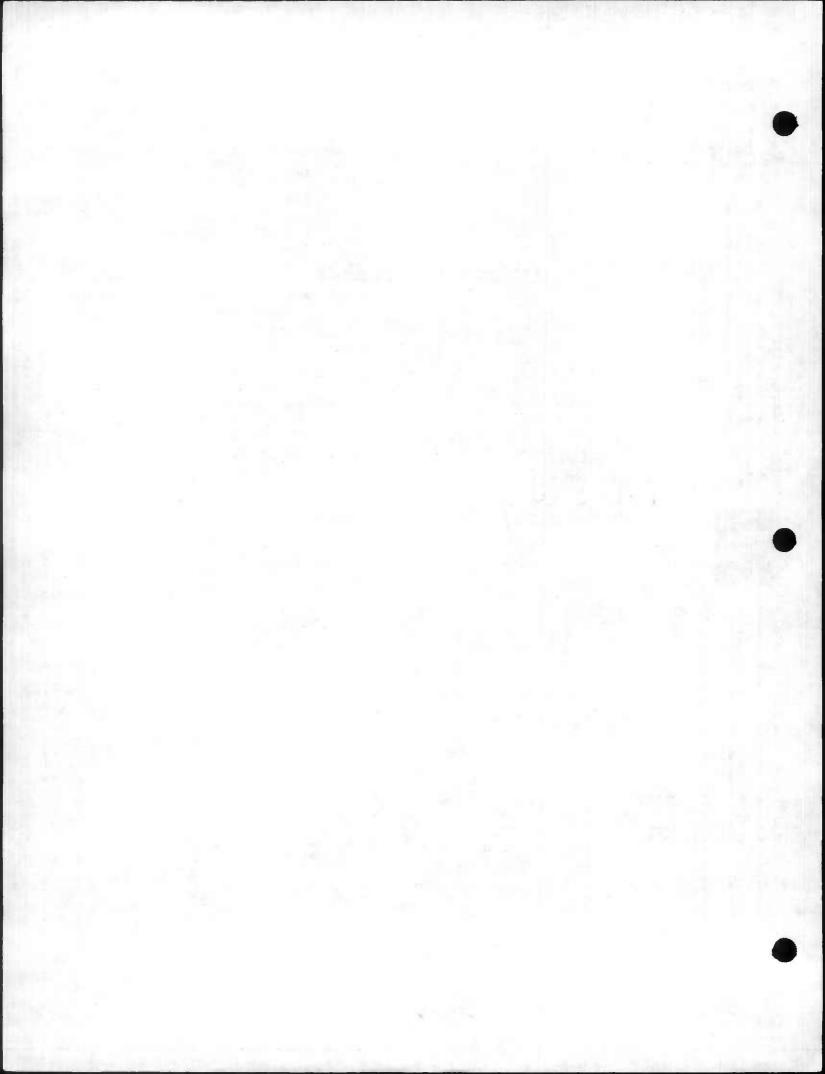
Completed Certification: To

State Registrar

25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death 28c. Injury at Work? N/A 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident NIA NIA NIA 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide NIA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and little of porti 29c. License number completed cause of death (Item 23a) (Type, Print)

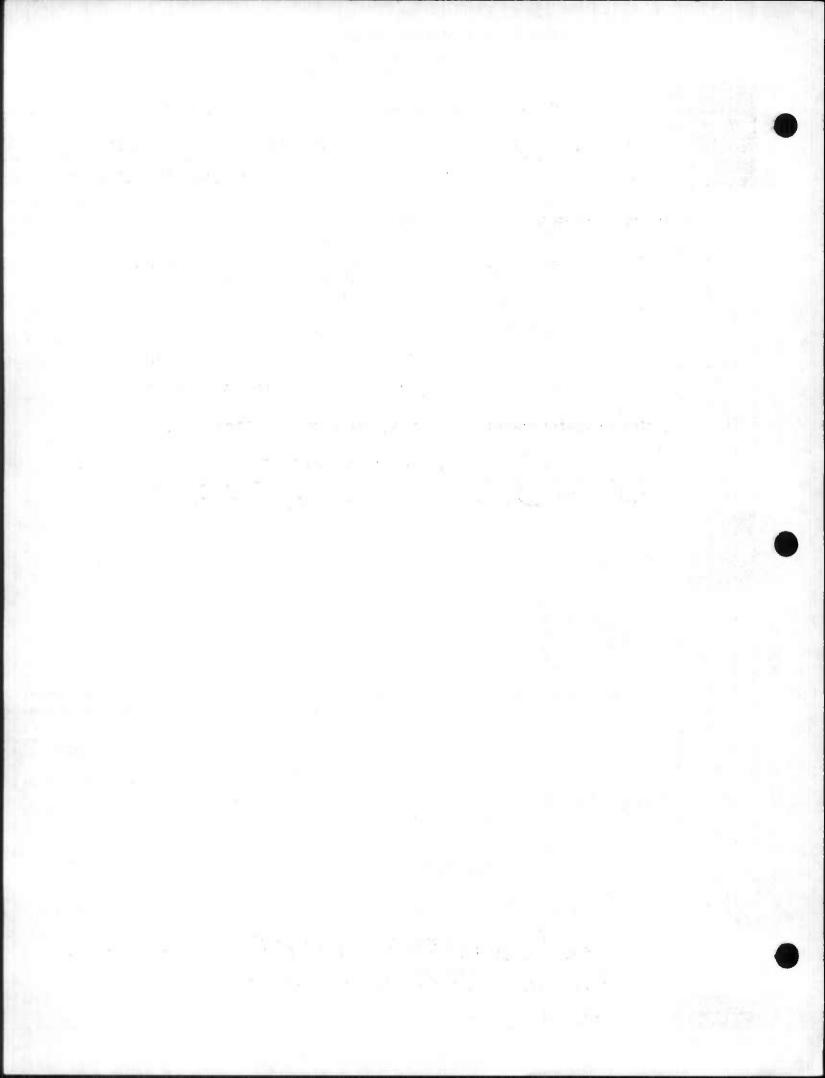
Frederick MDznoi Michael W. Levangie, MI 310

31. Date filed (Month, Day, Year) 32. Registrar's 1999



State of Maryland / Department of Health and Mental Hygiene 99 3 8 7

					Certificate of Death		Reg. No.	, ,	1017
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			VILLA ST. MICHA		EMMITSE			ERICK	
	Funeral Director	П	5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last bi		Min. (Month, D	orth Day, Year) 5.1915	9. Birthpla	ace (State or Foreign try) ESSEE
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	anyler show	-	10a. Stete 10b. County	10c. City, Tov				10	Od. Inside City Limits
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	Her d	Funerai		Armed Forces?	13. Was Decedent of Hispanic Origin if Yas, specify Cuben, Mexican, F	uerto Rican, atc.)	Blac	ck, White, e	
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no	8 = 5		1 Buriai 2 □ Cremation 3 □ Remo 4 □ Donetion 5 □ Other (Specify)	Vei from Steta	ary, crematory or other place)	112 /00			
Baltimore,	artmen ortanti Injury 8.		21. Signatura of Funerel Service Licensee	ST. JO	SEPH'S CEMETERY 9/ 22. Nama and Address of Fecility		EMMITSBU		ทบ.
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			20 Nome and address of the	ause "	1000	J	SEPTEMB	ER 10	,1999
			30. Name and eddress of person who comple ALAN CARROLL, MD.	ated causa of death (Item 23e) 310 S. SETON		MD.			
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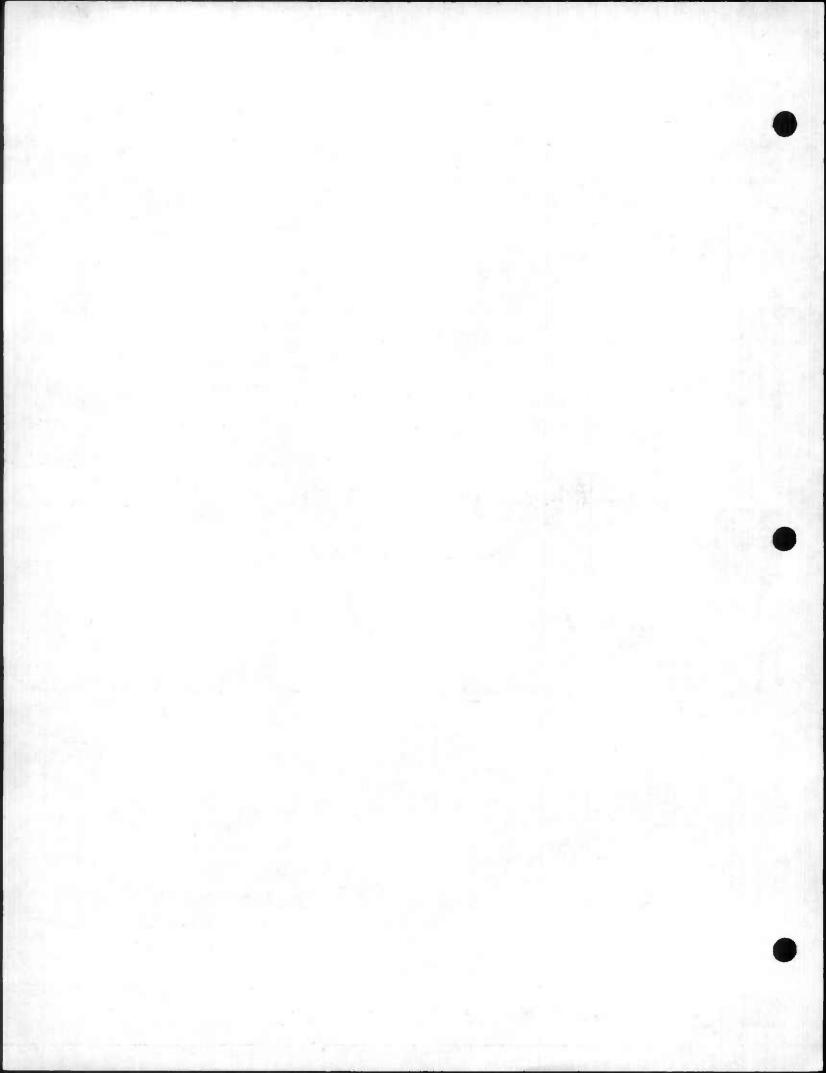


mnmr Richard J. Horton

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State of Maryland / Department of Health and Mental Hygiene Q Q 1 Q 1 Q

				Certificate	of Death	,	Reg. No.	3 3	1010		
	1. Decedent's Name (First, Middle, La	ist)			2. Date of De	eth	Year	3. Time of Deeth			
Physician /Medical	North Land	Richard .	J. Hor	ton		Augus	Dey st 27. 19	999	8:34 p.m.		
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Funeral	5. Social Security Number 6. S		in yrs. last bir	thday) If Under 1 Y Months D	eer If Under 24 Hrs mys Hours Min.		rth	9. Birthple	ace (State or Foreign		
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s 23a	699 Route 3 North	-			054		United				
- F	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	Bla	ea - America ck, White, e			
by F	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: 1 €	67-68	1□Yes 2⊠	No Specify:		Specify	Y: LTL d	40.00		
	15. Decedeni's E.			Decedent's Usual O	counstion		16b. Kind of B	Whi			
Be Completed	(Specify only highest gra	ade completed)	Toa.	(Give kind of work d	one during most of wo	rking	TOD, KING OF B	usii less/ii lu	ustry		
mo	Elementary/Secondery (0-12)	Coilege (1-4or 5+)		Carpen	ter		Cons	truct	ion		
0	17. Father's Neme (First, Middle, Last,)		oarpen		me (First, Middle	, Maiden Suman		1011		
0 8	Robert Earl Horton	1			Doris Wi	ndeor					
-	19a. Informant's Name/Relationship (19b	Meiling Address (St	reet and Number or R		er, City or Town.	State. Zio	Code)		
	Beverly Horton/ W	ife									
	20a. Method of Disposition		20b. Place of	Disposition (Name of	treet, Wil	Dete	20c. Location				
	1 ☐ Burial 2 ☑ Cremelion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			y, crematory or other	,	0/1/00	A 7 1				
y injur	21. Signature of Funeral Service Lices		Metrop	olitan Cr	ria,	Virginia					
ou .	Olin L. Molesworth P. A. Funeral Home										
sician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 26401 Ridge Road, Damascus, Maryland 20872 Approximate interval Between										
	shock, or heart feilure. List only	one cause on each line.	e death. Do r	lot enter the mode of	dying, such es cardia	c or respiretory e	errest,		interval Between Onset and Death		
n al	Immediate Cause (Final		W						onoctand bodin		
r	Immediate Cause (Final disease or condition Narcotic intoxication resulting in death)										
ē		Du	e to (or es e	consequence of):							
Examiner		b						i_			
Exa	Sequentially list conditions, if any, leading to immediate	Du	e to (or as a o	consequence of):				1			
- E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						1			
edical	that initiated events resulting in death) Last Due to (or as a consequenca of):										
2	d										
0	Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dfd tobacco use contribute it										
Physician/	Part II. Other significant conditions of	ontributing to death but i	lot resulting in	trie underlying caus	e given in Pert I.			3 □ Prob			
by P						10	Yes 207No	3 P100	ably 4 ☐ Unknow		
						24a. Was	an autopsy		re autopsy findings		
iete						perf	ormed?	соп	ilable prior to apletion of cause leath?		
Completed						· la.	V	12			
	25. Wise case referred to modis-1				00.5		Yes 2□No	04	Yes 2□ No		
o Be	25. Wes case referred to medical examiner?	Hospital:	WE EDIA	tration of soci	Other	ath (Check only		(2			
7: 70	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. 1	tpatient 3□ DOA ime of 28c.	4 Li Nursing i	Y	how injury occur)		
Certification:	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Y		3.4	Injury et Work? 1 ☐ Yes 2 ☑ No	Unknow					
2	3 ☐ Suicide 6 ☑ Could not b	e Ogo Place of Jaiwa		rm, street, factory, of			Street and Numb	per or Rural	Route Number.		
ert	4 ☐ Homicide determined	building, etc. (Specify)	in, strost, lastory, st	•	City or To Unknow	wn, State)				
	29a. Certifier 1□ Certifying Ph	ysician: To the best of m	v knowledge	death occurred at th	ne time, date and place			anner ac et	ated		
edicai		niner: On the basis of ex and menner stated	amination and	for investigation, in	ny opinion, death occi	urred at the time,	date and plece,	and dua to	the cause(s)		
M	29b. Sonature and title of certifier			29c. Lie	cense number		29d. Date signe	d (Month, E	Day, Year)		
	6/0	1			.C.M.E.		Augus				
	claim to	revo			· C • F1 • E •		Augus	20,	1777		
	30. Name and address of person who	completed cause of deat	n (Item 23a) (
24.1	31. Date filed (Month, Day, Year)	32. Registrer's	Signature		Street, B		e, Maryl	and 2	1201		
State istrar			Signature	1 4	Sparke						
	WILL U	- 1000 7	•	~.	sparker						
6/95					-						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item#28a, per doctor, 9/14/99 Certificate of Death FCHD, KS Reg. No. 1. Decedant's Nama (First, Middla, Last) 3. Time of Death Month **Physician** Harne Jr. Leslie. Coleman September 6, 1999
4b. City, Town, or Location of Death 4c. County of Death 4:38 PM /Medical 4a Facility Nama (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days M 2□F Hours Director 213-18-8271 78 1921 Maryland March 16, Usual Rasidence of Dacedani 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylar Yes 2 No Directo 288-7 Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 21702 7901 Opossumtown Pike U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas?

1 Xyas 2 No H Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. filed within 72 hours after 1 Navar Marriad 2 X Married ò 21215-0020 1 Yas 2 No Specify: P 3 Widowed 4 Divorced Year or Datas: WWII White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician N.I.H. Saltimore, Maryland 17. Father's Nama (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Leslie C. Harne, Sr. Miranda Catherine Redmond 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If Itam 27 is or other tra (Wife) 7901 Opossumtown Pike, Frederick, MD 21702 Marie Harne 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Removal from Stata 9/10/99 Frederick, Maryland 4 Donation 5 DOthar (Specify) Resthaven Mem. Gardens 21. Signature of Fonaral Sarvice Lie 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701 Approximata Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiretory arrest, **Physician** /Medical Immediete Causa (Final disaasa or condition rasulting in death) a. intracerebral Examiner Dua to (or as a consequence of): Examine The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in deviate. pue Dua to (or as a consequence of) Box 68760. physician Physician/Medical the that initiated evants resulting in death) Last Dua to (or as a consequence of): **USB 85** Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 ₽thknown for atrial fibrillation 1 ☐ Yes 2 ☐ No anticoagulation of Vital Records. bed p 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending Invastigation 1 Natural ne Hospital or Attending in 24 hours after death. he Funeral Director: Aft 1 ☐ Yes 2 ☐ No 9/5/99 the 2 Accident 6 Could not be datermined 3 ☐ Suicida Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and mannar steted. within 2 To the \$ 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 0 D0054705 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kathenne Buly

Frederick

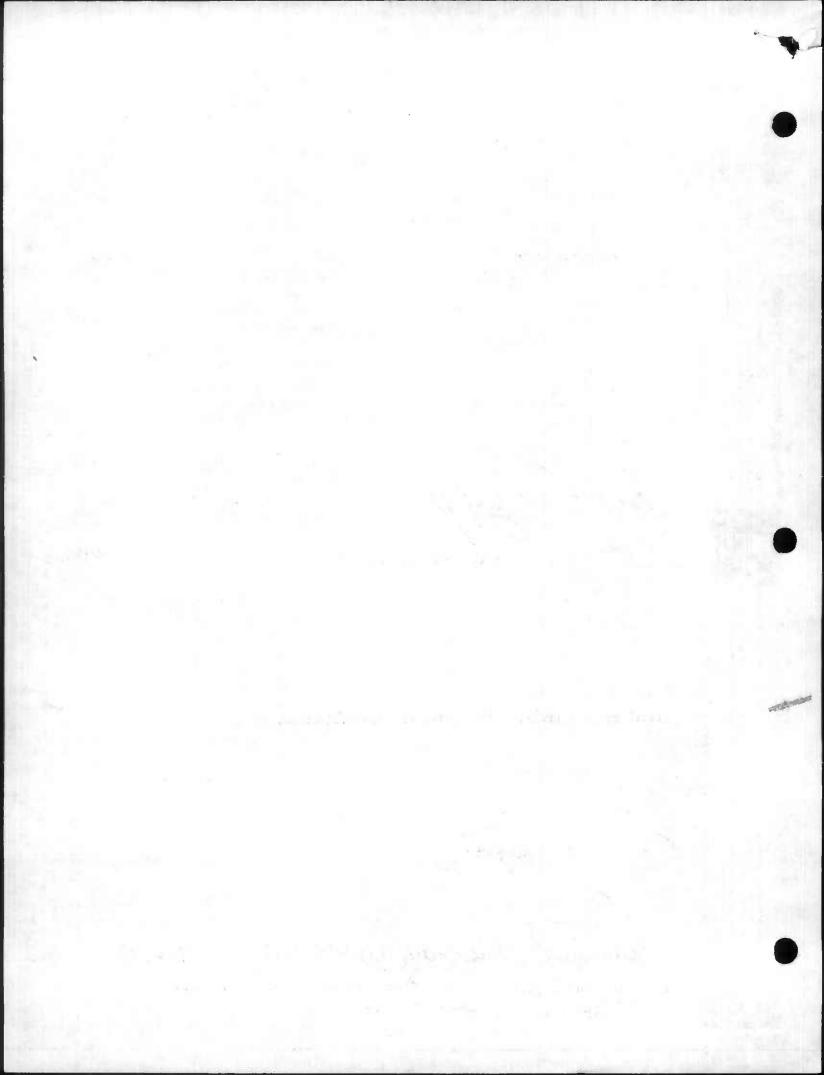
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West 9th St.

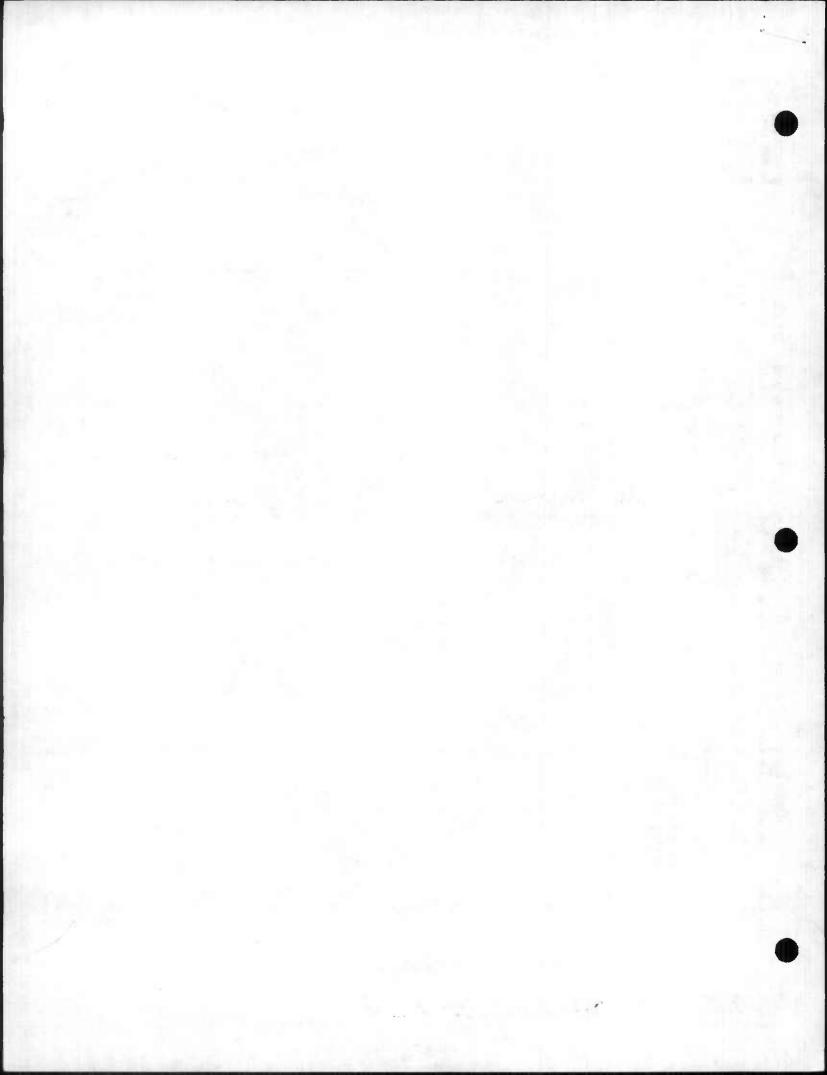
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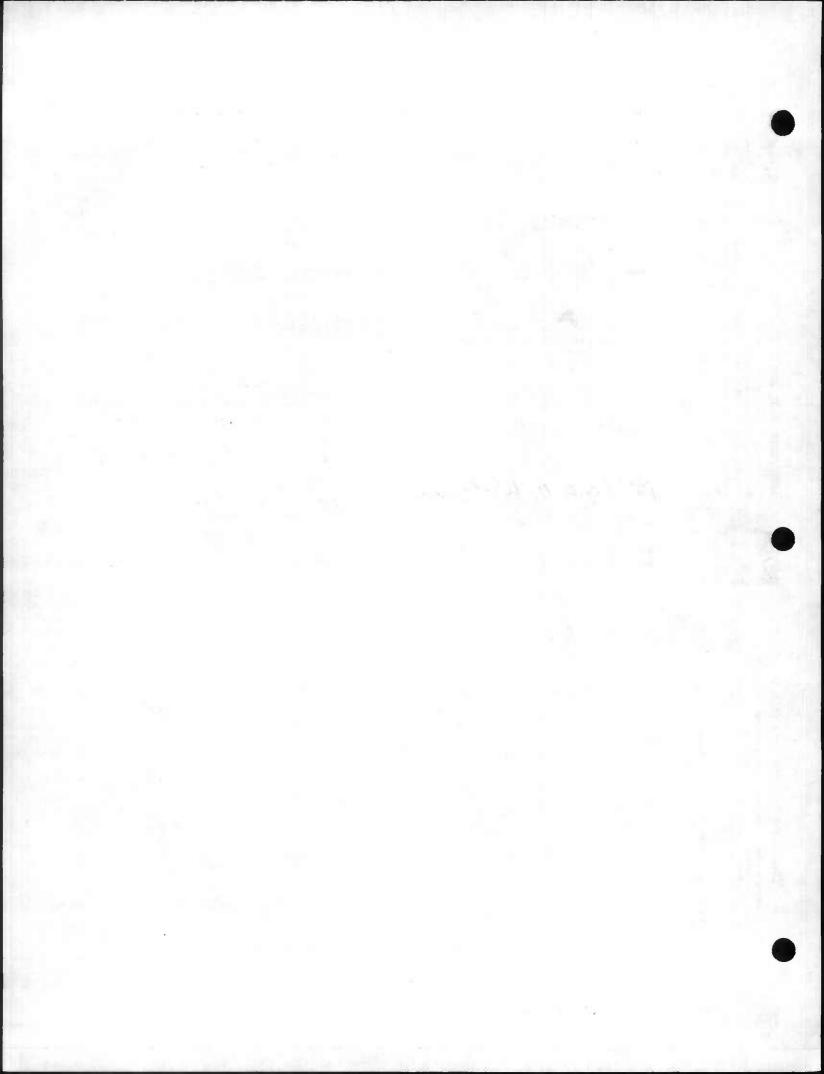


ian	A STATE OF THE STA	Idla, Last)				Death FC	2. Data of De- Month	Dev	Year	. Time of Death
cal	Catherine		Pear	1	HANK		Septem	ber 10,		10:00 pm
ner	4a Facility Nama (If not instituti Homewood R	-		r of Fre	1	4b. City, Town, or Frederic		on of Death 4c. County of Death Frederick		
	5. Social Security Number 219–46–2186	6. Sex 1 □ M 2	7. Aga (In	yrs. last birthday) 92 Yrs.		If Under 24 Hrs Hours Min	8. Date of Birt			o (State or Foreign
	Usual Rasidence of Decedant 10a. State 10b. Count	ty	100	: City, Town or L	ocation				10d.	Inside City Limits
the same of the sa	Maryland Fred	erick		Freder	rick					1. Yas 2□No
	10e. Street and Number 402 Elm Stree	t			10f. Zip Code	1701		10g. Citizen of \U.S.		
	11. Merital Status 1 Never Merried 2 Ma 3 Nidowed 4 Divorce	12. Was Armo	Decedent Ever ed Forcas? Yas 210 No as, Giva r or Datas:		Was Decedent of I If Yes, specify Cub 1 ☐ Yas 2X No	Hispanic Origin? (S an, Mexican, Puer	Specify Yas or No to Rican, etc.)	s or No- otc.) 14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decede (Specify only high Elementary/Secondary (0-12)		eted) ege (1-4or 5+)	(Giva	dent's Usual Occu kind of work dona DO NOT use retire nemaker	pation during most of wo d)	viking		Own Home	
1	17. Fathar's Nama <i>(First, Middle</i> Franklin	Lore	enzo	GOODMA	AN .	18. Mother's Na Lillia	ma <i>(First, Middle,</i> n Gal		PUTMAI	N
-	19a. Informent's Name/Relation Mr Richard H				ing Address (Street Culler A					
	20e. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (4 01-4-	ob. Piece of Dispo cemetery, cre It Olive	osition (Name of metory or other pla t Cemete:	cy Sep 1	Data 4, 1999	20c. Location - Freder		
	21. Signature of Funeral Sarvio	e Liceosee	€N MO		2. Name and Addra Keeney		rd P.A. Funeral Home t, Frederick, Maryland 21701 diac or respiretory errest, Approximeta Interval Batween			
resulting in o	disease or condition	(1)	nin alr	turntisz	- 00	svar ba	20,00	4120	. 10	LULA.
	diseese or condition rasulting in death) Sequentially list conditions, if any, leeding to immadiate causa. Entar Underlying Cause (Disease or injury	a((.)	Dua d	to (or as a consecto (or as a consec	quence of):	ngiona	sculir	61200	ett 6	lthr,
	disease or condition rasulting in death) Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Lest	a b c d	Dua d	to (or as a conse	quence of):	ng 10va	sculir	61200	ett (lyhn,
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	resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disaase or injury that initiated evants rasulting in death) Lest	c	Dua t	to (or as a consecto (or a consecto (or as a consecto (or a consec	quence of): quence of):		23b. Did	tobacco uss co	ontributs to the 3 Probabi	autopsy findings ble prior to etion of cause
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Medical Certification: 10 be Completed by Physician/Medical Examiner	resulting in death) Sequentially list conditions, if any, leeding to immadiate causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Lest Part II. Other eignificant conditions axaminar? 1 Yes 2 No 27. Manner of Death Invas 3 Suicide 4 Homicide 29a. Cartifier (Check only one) Conditions in the conditions of the conditions of the conditions of the conditions one of the conditions of	d. d. d. d. d. d. d. d. d. d.	Due to Du	to (or as a consect to (or as a consect to (or as a consect to (or es e consect to (or	quence of): quence of): quence of): quence of): anderlying cause given the cause given the course of the cours	26. Place of De her: year in Part I. 26. Place of De her: year ursing I was 2 No me, date and place opinion, daeth occupinion, daeth occupinion.	23b. Did 1	tobacco usa co Yes 20No an autopsy med? Yas 20No wa) danca 8 00th how injury occur Street and Numb wn, Steta) ceusa(s) and me data and placa,	24b. Ware availal comploid da 1 1 40 year or Rurel Roanner es state and dua to the	autopsy findings ble prior to elion of cause th? es 2 No nuta Number, d. e causa(s)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Dev Month **Physician** September 22, 1999 ocation of Deeth 4c. County of Death 1999 5:02 PM Ruth Hines /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Deeth **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Aug 25 19 Birthplaca (Stata or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1 □ M 2 🖾 F Yrs. 216-14-6370 80 Knoxville, MD Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits a hos 1 Yes 2 No Directo MD 28a-f Frederick Brunswick 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? ð must be 1100 Peach Orchard Drive 21716 USA or harms 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. after 1 Yes 2 No If Yes, Giva Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify. White ğ 72 hours 3 ₩ Widowed 4 Divorced "natural". Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry i filed within 7 i Hygiene. other then "n Elementery/Secondary (0-12) College (1-4or 5+) 8 Housewife Homemaker permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: If New 27 is married other any Injury or other to 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) Be **Everett Thomas Jones** Mary Edwina Meehan 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Dixon, Daughter 1612 Rohersville Rd, Knoxville, MD 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriel 2 Cramation 3 Ramoval from Stata Old Brethren Cemetery 9/25/99 Brownsville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funary I Service Licanse 22. Name end Address of Fecility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD Williams, Owner 21716 Barbara A. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or es e consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760 Physician/Medical Dua to (or es e consequenca of): esn Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 20 No 3 Probably 4 Unknown rebrovacci ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen has page 2 2 No 1 Yes 2 No certificate Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Mennar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the funi 5 Pending 1 ☐ Yes 2 ☐ No invastigetion 6 ☐ Could not be 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted. edicai 29e. Certifier (Check only one) 29c. License, number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/23/99 16675 lle air 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUGHER MINE 32. Registrer's Signeture 31. Date filed (Month, Day State 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 26, 1999 Ruth Virginia 10:15 AM /Medical 4a Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Odd Fellows Home Frederick Frederick If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) Virginia If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV. 13, 1915 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2XF 219-54-2243 83 **Director** Usuel Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits **Knoxville** 1 ☐ Yes 2 No Frederick Maryland Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2817 Point of Rocks Road 21758 U.S.A. Norna 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 72 hours after 1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1□ Yes 2□No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Sales Person Retail permit. Pages 1 and 2 should be filled wit Department of Health and Merital Hygiens Important: If Nem 27 is marked other that any Injury or other traumatic event man 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ada Lucy Snoots Jonas Alonzo Snoots 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Retationship (Type, Print) Mr. Carroll L. Hope, Son 6 Stull Drive, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal Irom Stete Resthaven Memorial Gardens. Sept. 29, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Funaral Service Licenses 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home J, MO0255 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate Interval Batween Onset and Death

Approximate Interval Batween Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Cerebrovascular accident minutes Examiner arteriosclerotic cerebro vascular obsease Examiner The lew requires that the death certificata be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Parkinson's disease, depression Division of Vitai Records, þ 24b. Were eutopsy lindings evellable prior to Completed 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannerol Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

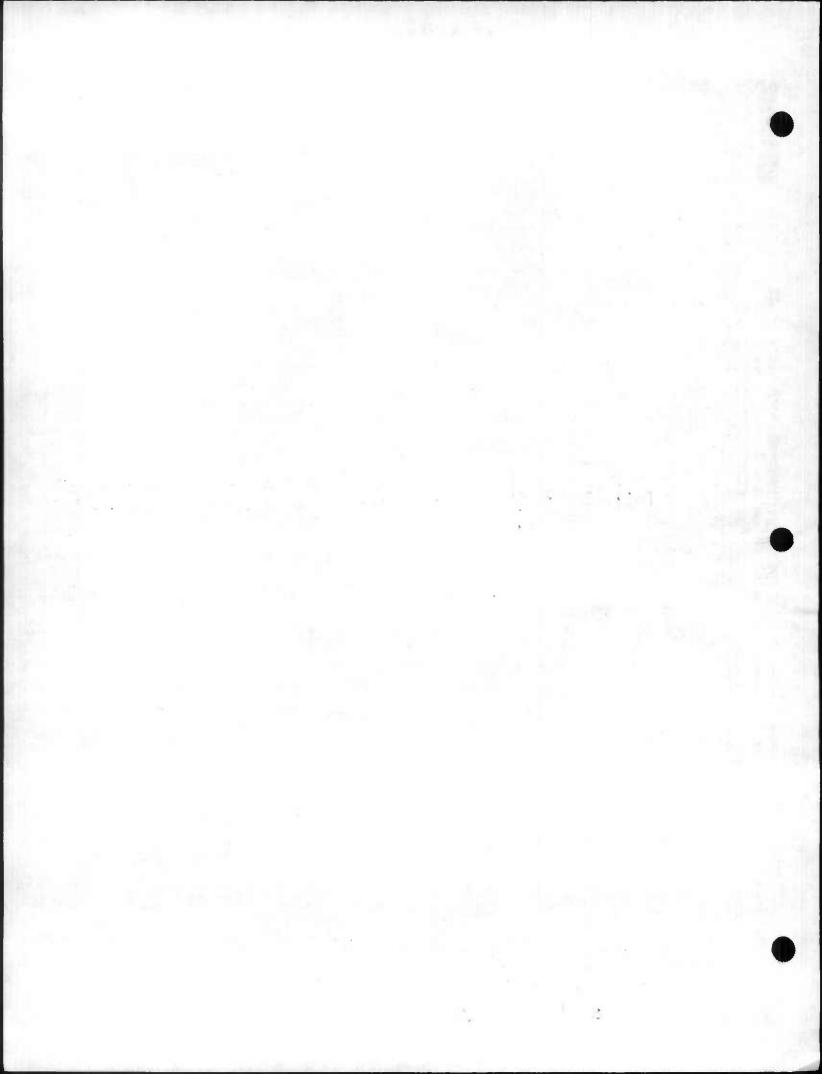
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number September 28, 1999 D 32073 athleen W Sken KD

State Registrar

31. Date liled (Month, Day, Year) SEP 2 8 1999

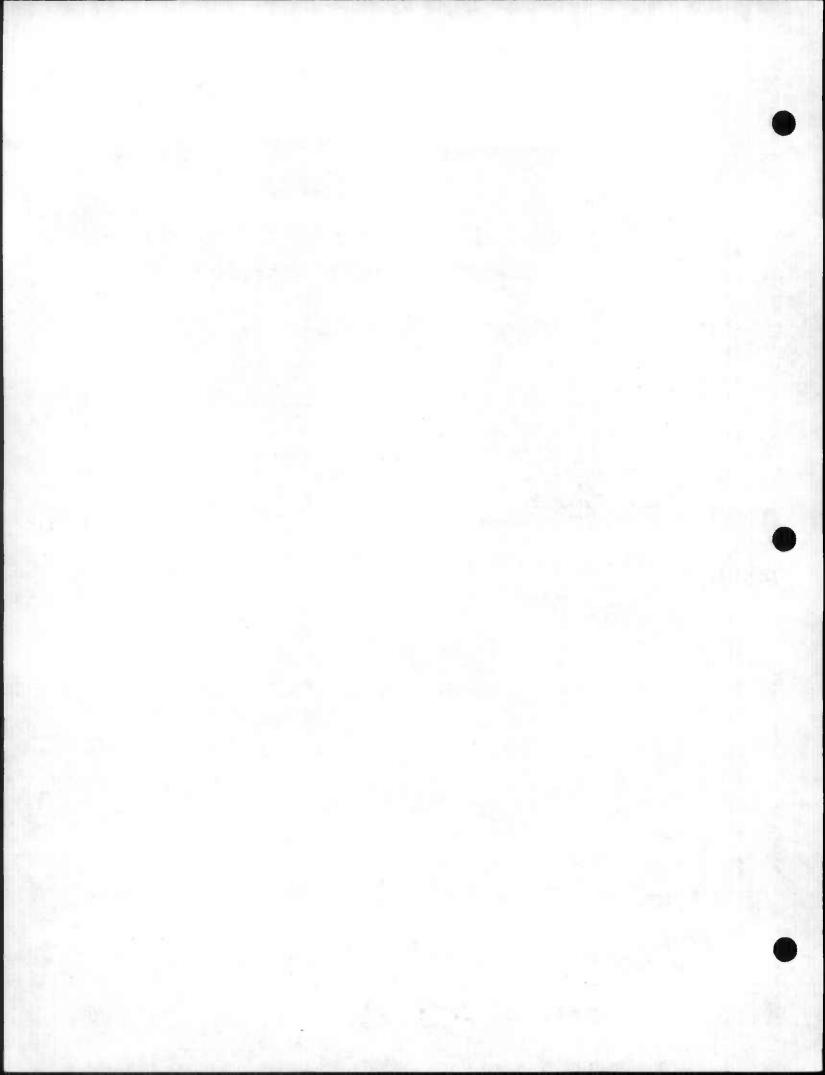
Kathleen W. Stern MD 610 Ninth Street, Brunswick, Maryland 21716 32. Registraru Signature

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene

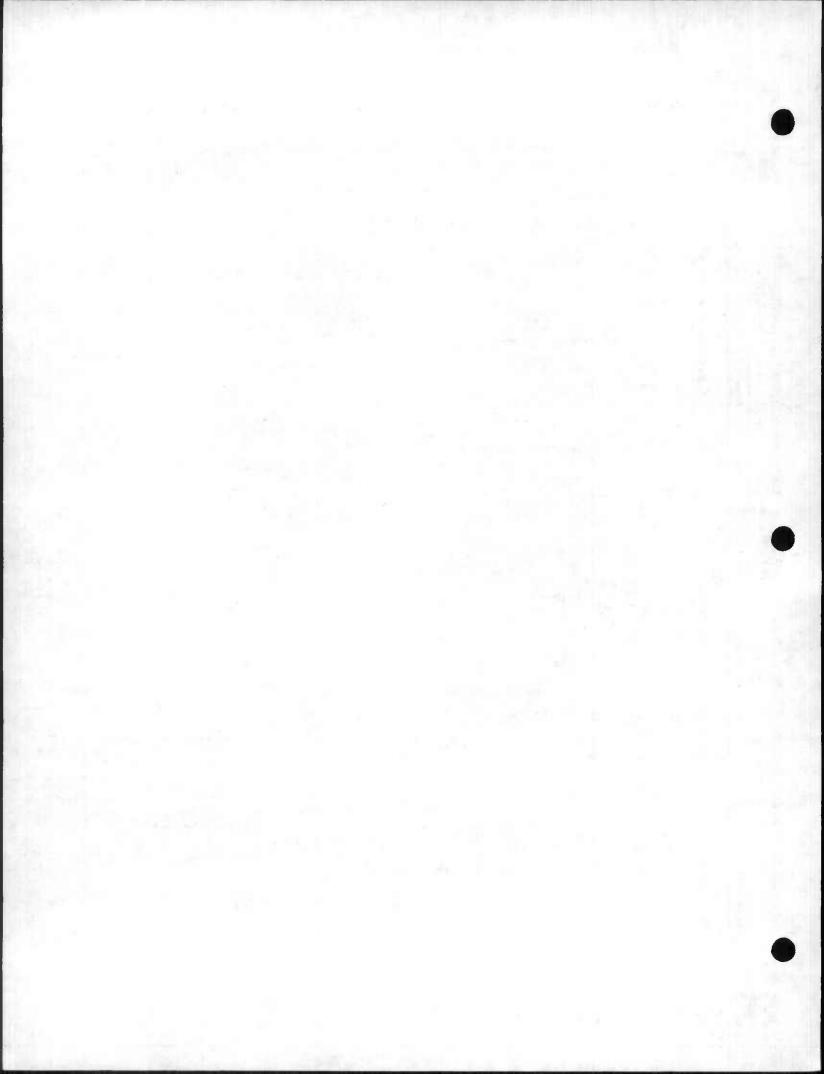
			C	ertificate of	Death	Re	g. No.	31823		
D)	1. Decedent's Name (First, Middle, Last)					2. Dete of Death Month	Day Veer	3. Tima of Death		
Physician /Medical	ROBERT	MICHAEL H	HOFFMAN	, SR.		SEPTEMB	ER 19 1999	12:36 a.m.		
Examiner	4a Facility Neme (If not institution, give s	treet and number)			4b. City, Town, or L	ocation of Death	4c. County of Dee			
	GLADE VALLEY NURS	SING HOME			WALKERSV		FREDERIC	CK		
Funeral Director	5. Social Security Number 6. Sex 213-16-0233	M 2□ F 7. Age (In)	rs. last birthde Yrs.	Months Deys		8. Dete of Birth (Month, Day, May 4, 1	9. Bir 911 Mary	thplece (State or Foreign ountry) y Land		
2	Usual Residence of Decedent	140	0): -					Toronto and a second		
e Maryla la-f ahov uned at	Maryland Frederic		City, Town or Walke	ersville				10d. Inside City Limits 11 Yes 2 □ No		
th with the Ma 23a or 28a-fa 11 be notified al Director	10e. Street and Number 11 Crum Road			10f. Zip Code 21793	3	10	g. Citizen of What Co USA	ountry?		
To be completed by Fundament Director To be completed by Fundament Director To be Completed by Funeral Director	11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Yeer or Dates:	1 U,S. 1	3. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2√2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Bleck, Whi	te, etc.		
led within 72 hoi hygiene. her than "natura nt, tra fed coll Completed	15. Decedent's Educ (Specify only highest grede	ation completed)	16a. Dec	cedent's Usual Occu	pation during most of work	kina 1	4c. County of Deeth FREDERICK Stee of Birth Fonth, Day, Year) 4, 1911 10d. Inside City Limits 12 Yes 2 □ No 10g. Citizen of What Country? USA es or No- etc.) 14. Raca - American Indian, Bleck, White, etc. Specify: White 16b. Kind of Business/Industry Dairy Farm 1, Middle, Meiden Sumeme) Imer 1e Number, City or Town, State, Zip Code) 1rederick, Maryland 21703 e 20c. Location · City or Town, State 199 Myersville, MD 21773			
mple and	Elementery/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retin	ed)		D			
offied work the vent, the	7		Far	mer	140 14 11 1 11			a .		
Mental H arked off atic ever	17. Father's Name (First, Middle, Last)					e Palmer	leiden Sumeme)			
2 should be and Menta Is marked aumatic ev	Michael Hoffman		100.11				0: T 0:-	7. 0. 13		
	19e. Informent's Name/Relationship (Type JoAnn Mentzer/Daug	hter	4605	Mocking		, Freder	ick, Mary	land 21703		
	20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ Re 4 □ Donetion 5 □ Other (Specify)		comology o	position (Name of rematory or other pla 1's Luthe:	ran Cemt					
permit. Pages Depertment of Important: if it any injury or onto	21. Signature of Funeral Service License	9		22. Name and Addr						
	23a. Part1. Enter the disease or complice shock, or heart failure. List only on	ations that caused the d						Approximete		
Physician /Medical	Immediate Cause (Final disease or condition		etate					Onset and Death		
Examiner 5	resulting in death) a.		o (or as a cons					0 9/1		
death certificate be assecuted a sitanding physician and of for use as the burial-transit ilclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a cons	sequence of):				1		
ficate be a physician is the buri	Cause (Disease or Injury that initiated events resulting in death) Last	Due to	(or as a cons	equenca of):				1		
ding I	d									
attan for u										
the ache	Part II. Other significant conditions cont	ributing to death but not	resulting In the	underlying cause g	iven in Part I.	23b. Did tol	e to the cause of death? Probably 4 Unknown			
been sign should be						24a. Wes ar perform		Were autopsy findings available prior to completion of cause of death?		
The law page 2						1□ Ye	s 2DMo	1 Yes 2 No		
certificate rector, pag	25. Was case referred to medical				26. Place of Dea	th (Check only one))			
	examiner?	spital: 1 Inpatient 2	! ☐ ER/Outpet	ient 3 DOA OI	her: A Salursing H	ome 5 Reside	nca 6 DOther (Spe	acify)		
	27. Manner of Death Netural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year	28b. Time Injury	/ Wo	rry at ork?] Yes 2 □ No	28d. Describe ho	w injury occurred			
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - A building, etc. (Spe	t home, farm,	street, factory, office		28f. Location (Str. City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
To the Hospital or within 24 hours after To the Funeral Direction of the Completely filled in Medical Cert	29e. Certifier (Check only one) Certifying Physical Examination (Check only one)	olan: To the best of my ker: On the basis of exam and manner stated.	knowledge, de inetion and/or	eth occurred et the t investigation, in my	ime, date end place, opinion, deeth occur	end due to the ca red at the time, de	use(s) end menner e te end plece, end du	s stated. e to the ceuse(s)		
Within To the comp	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mon	th, Day, Year)		
	Herrelle	MD			1058		09/20/99			
	30. Name and address of person who cor	10 ac	100 COC	e, Print)	Rd. W	budsbon	au ,o	21798		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrers Sig	neture	B. A	parks)					



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CARMEN HOLTZ September 18, 1999 5:00 p.m. /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** Glade Valley Nursing and Rehab. Center Walkersville Frederick 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□YF 85 Yrs. 214-10-2483 Sept 8, 1914 Director Maruland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Directo Libertytown Maruland Frederick 10g, Citizen of What Country? 10e. Street and Number 10f Zip Code 'natural', or flerne 23a or 11920 Main Street Unit 107A 21762 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Detas: 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify. à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) Unknown unknown Seamstress Men's Suit Manufacture nd 2 should be flied ith and Mental Hygie 27 is marked other r traumatic event, the 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be John M. DeBerry 2 Nita B. Staub permit. Pages 1 and 2 sh. Department of Health and Important. If them 27 is me. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1011 Arlington Blvd. Arlington, VA 22209 Kenneth Reed / nephew 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Burial 2 Cramation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Haugh's Church Cemetery 19/21/99 Ladiesburg, PA 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Smallure of Funaral Service Licensee 104 E. Main Street, Thurmont. 23e. Pert1. Enter the disease, or complications that caused the deeth phot enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only ona causa on aach line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 1 Monk CONGESTIVE HEART disaase or condition resulting in death) Examiner Due to (or es e consequence of): 1 Month Examiner Effusion physician and the burial-transit Sequentielty list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): P.O. Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 tnpatient 2 EP/Outpatient 3 DOA To Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: al or Attanding P s after death. I Director: After i d in by the funer After 1 Netural 5 Pending Investigation 1 | Yes 2 | No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Cartifier 11 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of carelie D43091 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

80 1 TOLL HOUSE Ave Fredorich SAEED 32. Registrent Signeture 31. Dete filed (Month, Dev. Year) State SEP 2 0 1999 Registrar



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) Day Year September 15,1999 ion of Death 4c. County of Death Claude Pau1 Hamburg 4:31 pm 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Frederick Memorial Haospital Frederick Frederick Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. Hours Min. If Under 1 Ye 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 10XM 20 F Days Months 220-03-5862 84 Nov 25. Maryland Usual Rasidance of Decedent 10d. Inside City Limits 10c City Town or Location 10a Stata 10h County 1 Yes 2 No Maruland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5746 Butterfly Lane United States 21703 Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Yas 2 No 1942 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Yaar or Datas: -1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Collega (1-4or 5+) Elemantary/Secondary (0-12) TRANSPORTATION 10 US GOV'T 18. Mother's Nama (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Orville Hambura Annie Elizabeth Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 5746 Butterfly Lane, Frederick, MD 21703 Charlotte Abrecht Hamburg 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 9/20/99 Frederick, Maryland Olivet Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signatura of Funaral Sarvice Licensee 1621 Opossumtown Pike, Frederick, Md The Do not similar the mode of dying, such as cardiac or respiratory arrest, 21702 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one ceuse on each in the shock of th Approximate Interval Between Onset and Death MYOCARDIAL INFARCTION Immediata Causa (Final disaasa or condition rasulting in daath) CORONARY ARTERY Sequentially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case rafarred to medicat axaminar? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

à

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryla Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic avent, the Hedgel Example must be notified an obta.

Baltimore, Maryland 21215-0020

the Meryland

Examiner

Physician/Medical þ

attending physician and for use as the burial-transit SE signed by t peed certificate Be in 24 hours after deeth.

The Funeral Director: After this letely filled in by the this Certification:

Completed 2 27. Mannar of Death

Medical

29e. Cartifian (Check only one)

1 Netural

2 Accident

3 ☐ Suicide

6 Could not be datamined 4 Homicida

28a. Dete of Injury (Month, Day Year) 5 Panding invastigation

28b. Time of Injury

28c. Injury at Work?

28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signeture and title of celtifian cuv.

1 Yes 2 No

29d. Date signed (Month, Day, Year) SEPTEMBER 15, 1999 TANTY AVE # 204 FREDERICK MD 21702

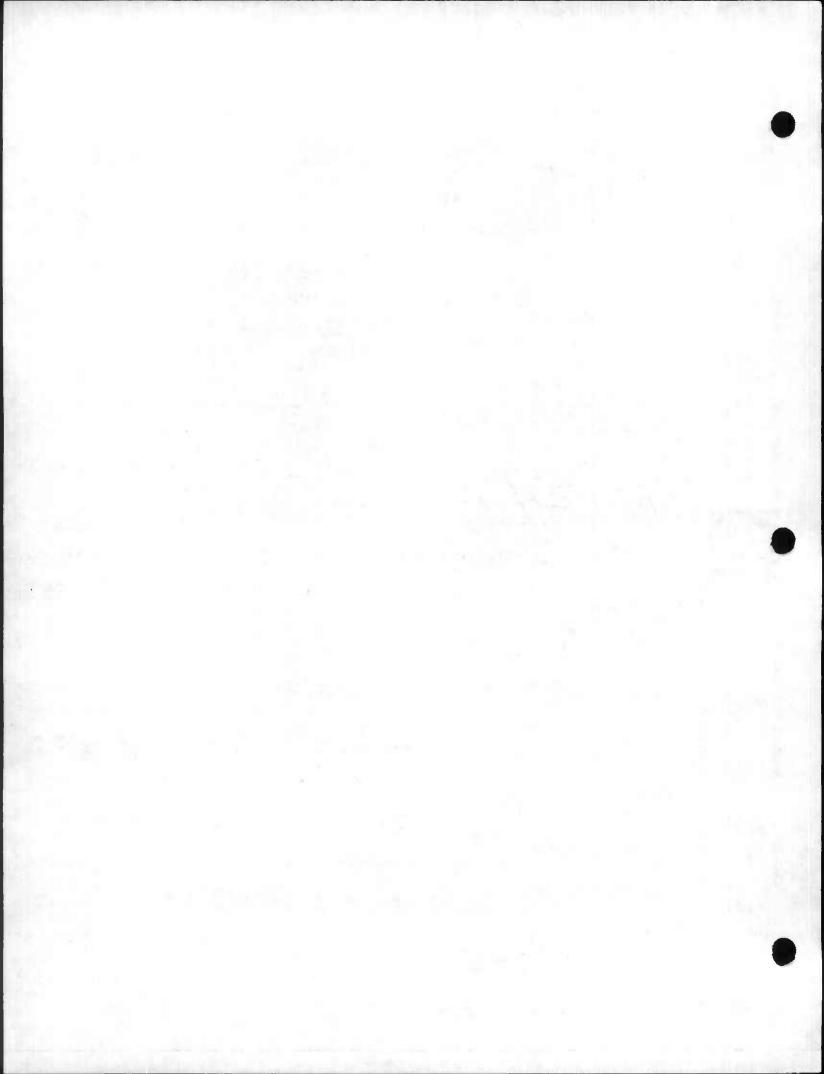
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) MD WARAVORICAR,

32. Registrare Signatura 31. Data filed (Month, Day, Year) 1999

State Registrar

within 2 the

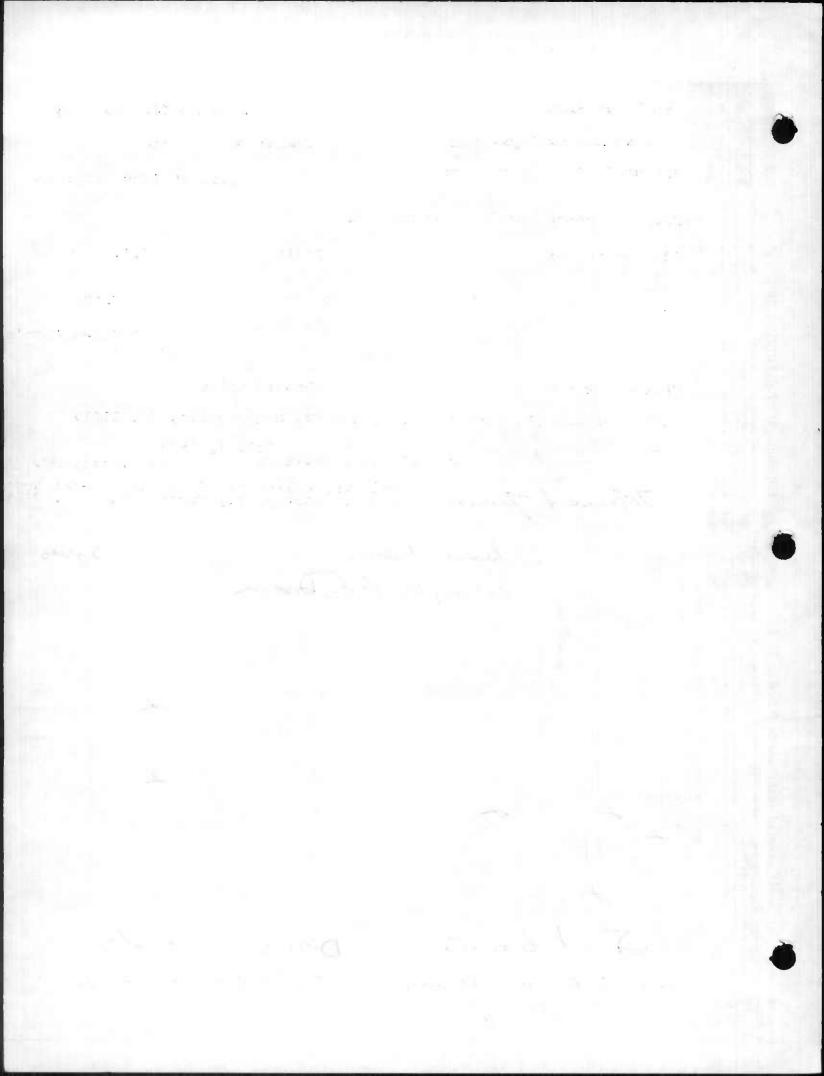
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State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Daath 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month Dav Year **Physician** Martha Mae Holden September 28, 1999 07:45 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, give street and number) 4c. County of Death Examiner Kent & Queen Anne's Hospital Chestertown If Undar 1 Yaar 5. Social Security Number If Under 24 Hrs. 9. Birthplace (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 6. Sex **Funeral** 1□ M 2√√ Months Days Yrs. 221-05-3740 79 **Director** April 25,1920 Maryland Usual Rasidance of Decedent with the Meryland r 28a-f show 10a Stata 10c. City. Town or Location 10d. Inside City Limits 1⊈ Yes 2 No Queen Anne's Centreville Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7 is merked other than "natural", or items 23s or traumatic event, tra Medical Examinor must be r U.S.A. 21617 209 Oak Street permit. Peges 1 and 2 should be filed within 72 hours efter death a Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s any Injury or other traumatic event. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No. If Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 □ Ne Specify: Specify: White ð 3€Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Kent & Queen Anne' College (1-4or 5+) Elamantary/Secondary (0-12) Hospital Nurse 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middle, Last) Bessie Butler Charles Engrem 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) P. O. Box 87, Centreville, Md. 21617 Bess Sterling (Daughter) 1 20c Location - City or Town, Stata 20b. Place of Disposition (Nama of cemetary, cramatory or other place) Oct. Date 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Templeville Cemetery Templeville, Md. 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
408 S. Liberty St., Centreville, Md. 216 21. Signature of Funeral Service Licansee larces 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only on-cause on each line. Approximata Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaase or condition resulting in death) /Medical 5 years Examiner Examiner CI physician end the buriel-transit death certificate be executed Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated evants resulting In death) Last P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): 80 use 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No. 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? ate hes b 1 Yes 2 DAVO 1 □ Yas 2 □ No certificate or Attending Physician: funeral director, 25. Was cesa rafarred to medicel axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 Ao ☐ Impatiant 2☐ ER/Outpatient 3☐ DOA 20 After this 28a. Data of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1- Enatural 5 Pending efter death. 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be 3 ☐ Sulcida 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 ☐ Homleida 24 hours e Hospital **Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 e E 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifiar 29c. Licansa number 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Obstation Md 2/620 1c. Ross 516 mo Was hington

State Registrar 32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No, 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death SEPTEMBER 1, 1999 **EMMA** JAMES. SOPHIA 6:05 PM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 20 F Yrs. 212-14-6264 90 Jan 14, 1909 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10e. State 10d. fnside City Limits Maryland Frederick Jefferson 1 Yes 2√ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3857 Jefferson Pike 21755 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 1 Never Married 2 X Married 1 ☐ Yes 2 No If Yes, Give 1 Yes 2 No Specify: specity: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Seamstress Tailoring Company 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Charles H SHULL Cora LITTLE 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr George Thomas Jamse/Husband 3857 Jefferson Pike, Jefferson, Maryland 21755 20b. Place of Disposition (Name of cemetery, crematory or other pleca) 20a. Method of Disposition Date 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Mt Olivet Cemetery Spt4, 1999 Frederick, Maryland 22. Name end Address of Fecility Keeney & Basford P.A. Funeral Home 21. Signeture of Funeral Service Licansee M00706 106 East Church St, Frederick, Maryland 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in deeth) nevinania Due to (or es e consequence of): Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: ► Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

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To the Hospital o within 24 hours af To the Funerel Di completely filled in

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Certification:

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Box 68760

P.O.

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Division

Physician

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Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Physician/Medical é Completed

	Wes case examiner?		to	medical	
	1 Yes				
27.	Manner of	Deeth			

28e. Dete of Injury (Month, Dey Year) 5 Pending Investigation 6 Could not be determined

28b. Time of 28c. Injury et Work? 1 Yes 2 No

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 Naturel

2 Accident

3 ☐ Suicide

4 Homicide

1. Certifying Phyeician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier,

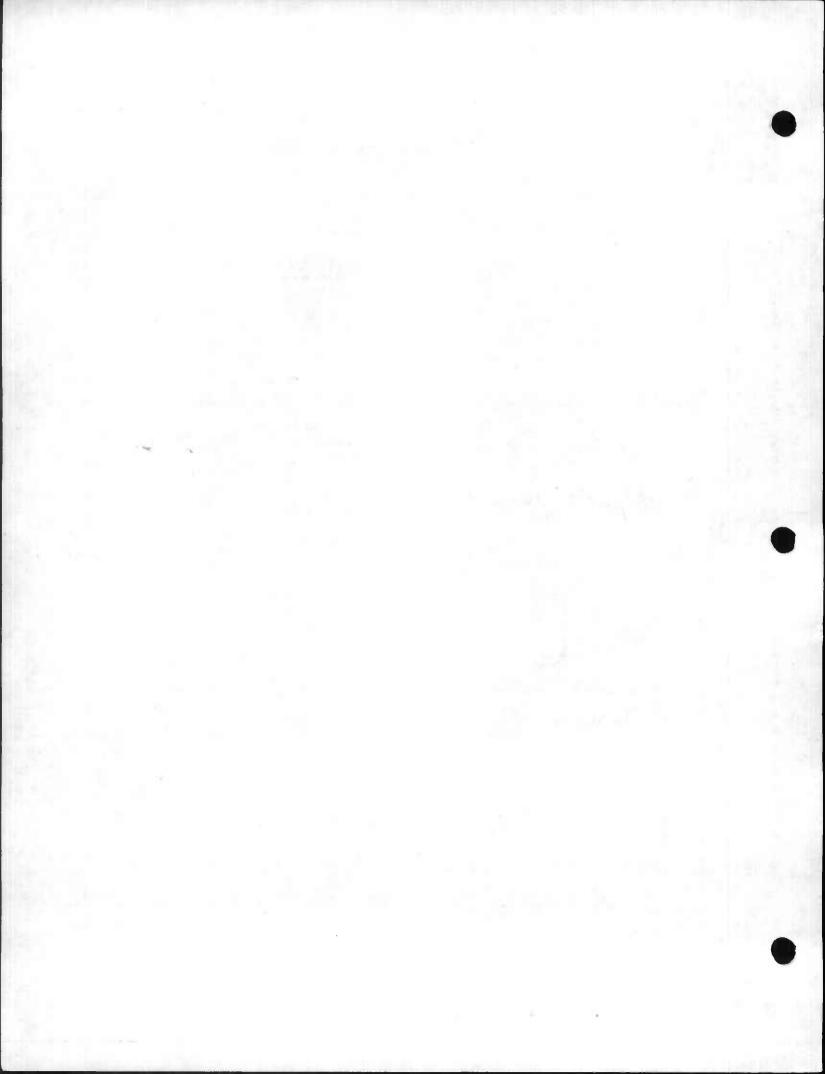
29c. License number

29d. Date signed (Month, Day, Year)

30, Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

afr lewins 32. Registra s Signature 31. Dete filed (Month, Day, Year) 9 32 1899

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev **Physician** Alvina Kranz 8:30 AM September 3,1999 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glade Valley Nursing & Rehabilitation Center Walkersville Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1 □ M 2 🖾 F Months Hours 330-20-9159 Director 76 Aug. 18, 1923 Minnesota Usual Residence of Decedent with the Merylend 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11899 Barley Court 21770 Funeral United States death 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No If Yes, Giva 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours efter 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grede compiated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry I Hygiane. Collega (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be fi Department of Health and Mentel H Important: If Item 27 is marked off any injury or other traumatic even Mentel 2 Stanley W. Price Theresa Gajeski 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21770 Tom Kranz / Son 11899 Barley Court, Monrovia, Maryland 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 DiCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 9/4/99 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Olin L. Molesworth P. A. Funeral Home 23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failura. List only ona causa on each tine. 20872 Approximate Interval Batween Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner The law requires that the daath certificeta be executed buriel-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseese or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Box 68760. physicien Physician/Medical the th Due to (or as a consequence of): ed by the attending datached for use as Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Ware autopsy findings eveileble prior to completion of cause of death? 24a. Was an eutopsy performed? peen: has certificata 1 Tes 1 ☐ Yes 2 ☐ No or Attending Physician: 'efter death.'
Director: After this certifica funeral director, Be 25. Wes case rafarred to medicat exeminer? 28. Placa of Daath (Check only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28b. Tima of 28d. Dascribe how Injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accidant the 6 Could not be datermined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straet, factory, offica building, etc. (Spacify) filled in by 4 - Homicide To the Hospital o within 24 hours of To the Funeral D' completaly filled i 29a. Certifiar (Check only one) Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and mannar as stated.

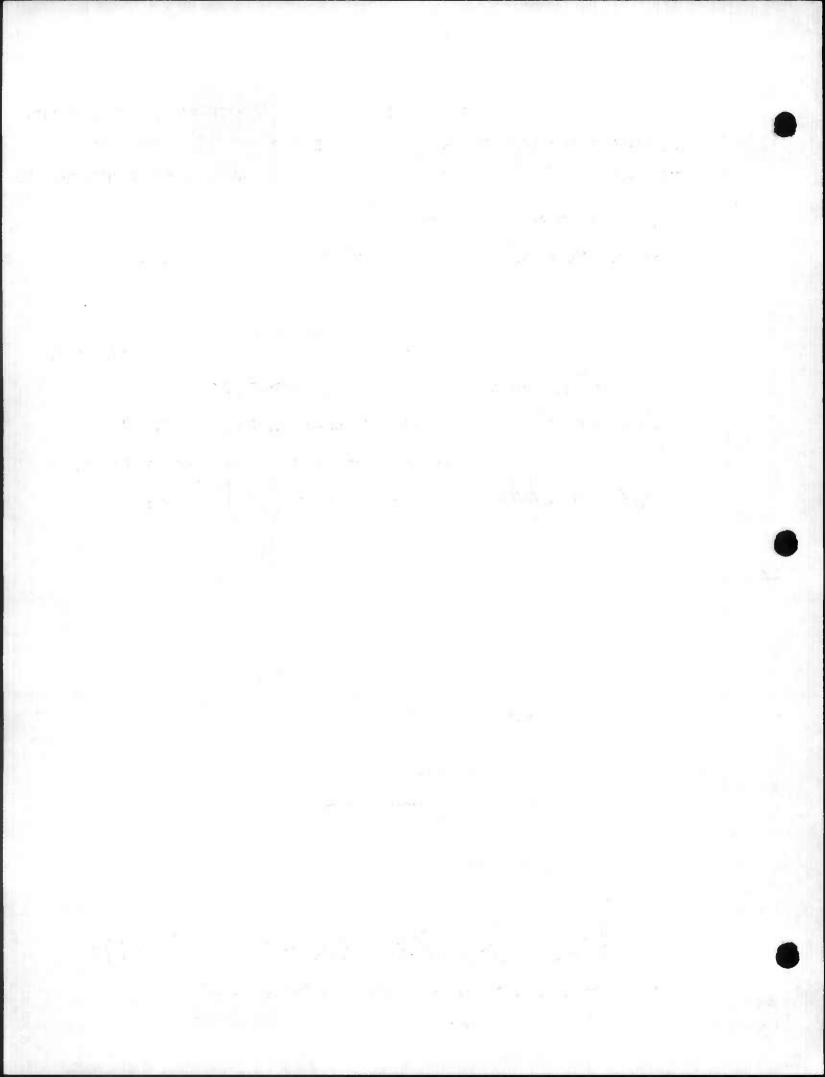
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and mannar stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) on who complated cause of death (Itam 23a) (Type, Print) 1475 Registra s Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day **Physician** KNOTT NORA MABEL SEPTEMBER 5, 1999 6:00 A.M. /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** ST. CATHERINE'S NURSING CENTER **EMMITSBURG** FREDERICK If Under 24 Hrs. 8. Deta of Birth (Month, Day, Year)
JUNE, 26, 1906 If Undar 1 Yaer 5. Sociel Sacurity Number Birthplace (Stata or Foraign Country) 7. Age (In yrs. lest birthdey) **Funeral** Months Days **Director** 219-12-1120 93 EMMITSBURG, MD. Usual Rasidance of Decedant death with the Maryland 10e. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits 1 Yas 2 No Director MD. FREDERICK THURMONT 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 16118 KELABAUGH RD. 21788 U. S. A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or item any injury or other treumatic event, the Modiful Exercise Black, Whita, etc 1 ☐ Yes 2 🕱 No If Yas, Giva 1 Navar Merried 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: P Specify: 3 Ø Widowed 4 □ Divorced WHITE Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) SEAMSTRESS CLAIR FROCK, MFG. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) MARTIN I. HARBAUGH BESSIE LONG 2 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) ALLEN KNOTT/ SON 16160 KELABAUGH RD., THURMONT, MD. 21788 20e. Method of Disposition 20b. Place of Disposition (Nema of cematary, cramatory or other piace) 20c. Location - City or Town, Stata 1X Burial 2 ☐ Crametion 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Othar (Specify) ST. ANTHONY'S SHRINE 9/8/99 EMMITSBURG, MD. 21. Signeture of Funeral Service Licenses 22. Nama and Addrass of Facility SKILES FUNERAL HOME MAIN ST., EMMITSBURG, MD: 21727 Entar tha disaasa, or complications that caused tha daeth. Do not antar the mode of dying, such es cardiec or respiretory errest, or haart failure. List only one causa on each line. Approximata Intarval Between Onset and Death Physician /Medical Immediate Causa (Final disease or condition rasulting in daath) Examiner Examiner the attending physician and hed for use as the buriel-transit The law requires that the death certificeta be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. should be detached 23b. Did tobacco use contribute to the cause of death? signed by 2 No 3 Probably 4 Unknown 1 Yas þ 24a. Was an autopsy performed? 24b. Wara autopsy findings avellable prior to complation of causa of death? Completed peeu certificate has b director, page 2 s 1 Tas 1 Yas 2 No d or Attending Physician: after death. Director: After this certific 25. Was casa rafarred to medical exeminar? Be 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Homa 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Rasidance 8 ☐ Other (Specify) 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of Injury 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 1 X Natural 5 Panding invastigation 1 Yas 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Sulcida 28a. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral C Hospital 1 Cartifying Physician: To the best of my knowledga, death occurred at tha time, dete and piace, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, deta and place, and due to the cause(s) end manner stated. Medical 29a. Cartifiar (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addrass of person who completed cause of deeth (Item 23a) (Type, Print) ALAN CARROLL, M.D., 310 S. SET(31. Data filad (Month, Day, Year) 32. Registrar's Signature SETON AVE., EMMITSBURG, MD. 21727 State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Caroline Beatrice Kellv September 23, 1999 12:20 A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood Retirement Center Frederick Frederick If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 92 Yrs. If Under 1 Yaar 8. Date of Birth Dec. 19 Year 1906 9. Birthplace (Stete or Foreign **Funeral** Days Months Houra 1 □ M 2 🛛 F 220-52-1550 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inaide City Limits ms 23a or 28a-f show Maryland Frederick Director Frederick Yes 2 No 10e. Streef and Number
31 West Patrick Street 10f. Zip Code 10g. Citizen of What Country? Nerne 23a or 21701 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Marifal Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or flee any Injury or other traumatic event, the Medical Esaminan Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 specify: White 1 ☐ Yes 2 No Specify: PV 3 DWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be Daniel W. Zentz Effie Lohr 19a. Informant's Name/Ratationship (Type, Print)
Dr. Donald Z. Koons/Son 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 612 Schley Ave., Frederick, Md. 21702 20b. Place of Disposition (Nema of 20c. Location - City or Town, State 20a. Method of Disposition Blue Ridge Cemetery 1 Burial 2 Cremation 3 Removal from State Sept. 27, 1999 Thurmont, Md. ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately, and the course on each line. Interval Between Onsat and Death **Physician** /Medical Immediate Causa (Final IMONTH disease or condition rasulting in death) Examiner Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed l þ cate has been si 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ∏Yas 2 ∏No of Vital 25. Was casa raferred to medical examinar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yea 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1. Natural 2 Accident 5 Pending investigation n 24 hours after death.

• Funeral Director: Aft bletely filled in by the fur 1 Yas 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) To the F within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and fitle of certifier September 24, 1999 D09689 arr-30. Name and addrass of person who completed cause of death (Item 33) (Type, Print) A. Austin Fearre, Jr., M.D., 300 West Ninth Street, Frederick, Md. 21702

Registrar **DHMH 16 Rev 6/95**

State

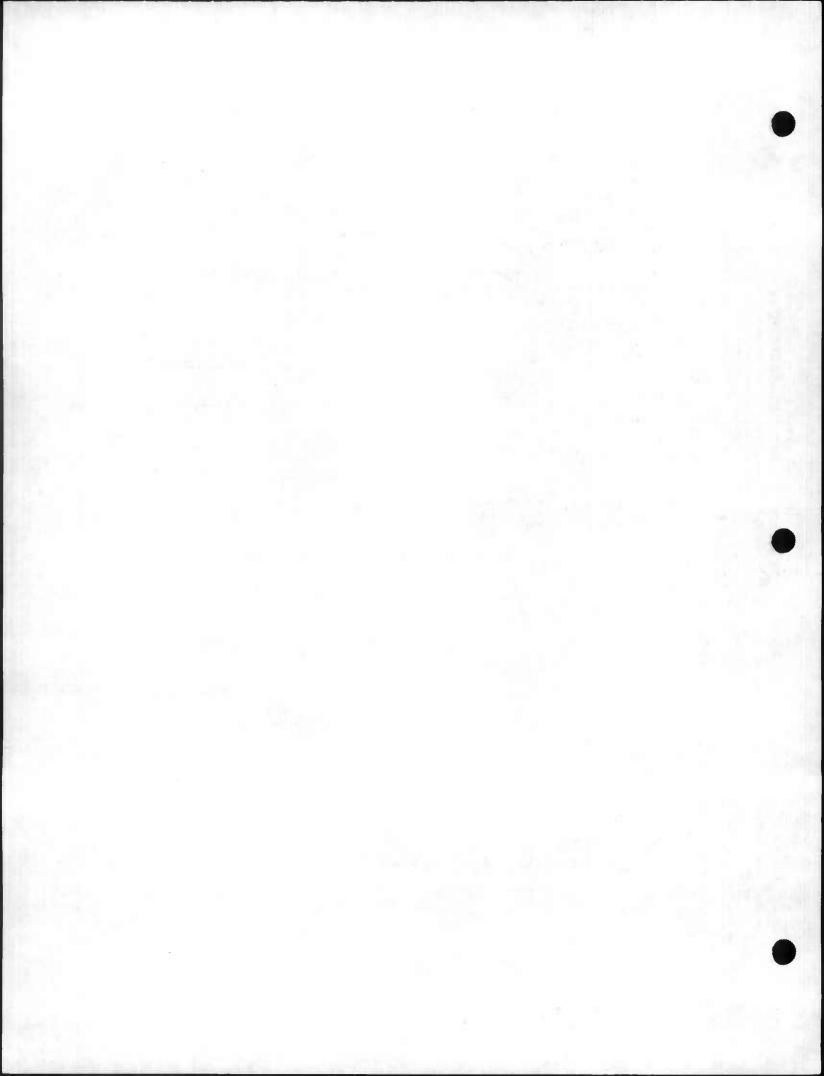
31. Date tiled (Month, Dey, Year)

32. Regisfrar Signatura

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Box 68760. P.O. Records,

Division

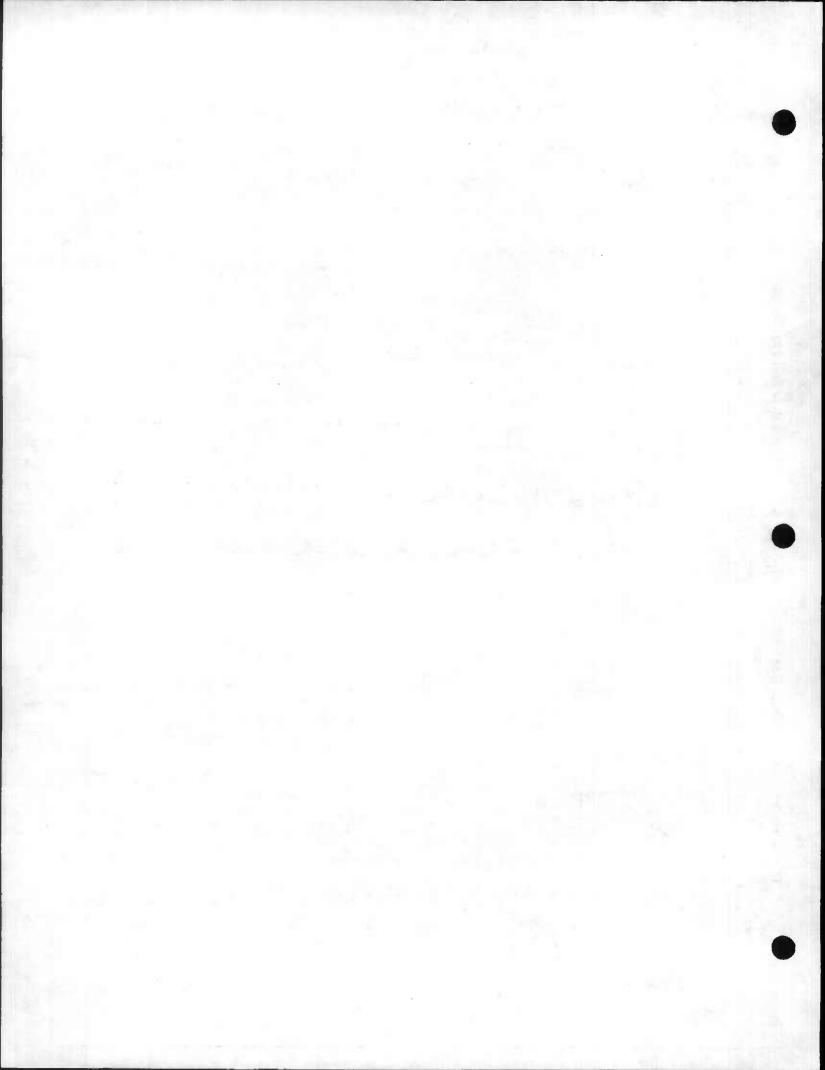


James Francis Lawhead II

State of Maryland / Department of Health and Mental Hygiene

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Dhue	alan.	1. Decedent's Neme (First, Middle, La	st)				2. Date of De Month	ath Dey	Year	3. Time of Death	
Phys /Me	dical		ancis Lawhea	d II			Septem	ber 3.	1999	6:22 a.m.	
Exan	niner	4e Facility Neme (If not institution, give				4b. City, Town,	or Location of Deat	4c. County	of Death		
		10002 Baltimore			If Under 1 Year	Myersvi		Frede			
Funera Directo		5. Sociel Security Numbar 6. S 216-50-8825 Usuel Residence of Decedent	ax 7. Age (In yrs. las 50	Yrs.	Months Days		lin. 8. Dete of Bir (Month, Da May 13	, 1949	Coun	lace (State or Foreign try) ington D.C.	
death with the Maryland ma 23e or 28a-f ahow mast be notified at		10a. Stete 10b. County	10c. City,						1	0d. Inside City Limits	
	to	Maryland Freder	ick My	ersvi	.11e					1 ☐ Yes 2130No	
5 th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	try?	
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21215-0020 d within 72 hours after death with the Marylar glene. pr than "natural", or itema 23a or 28a-f ahow, the Machel Examiner must be motified at	by Funeral	11. Marital Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S. Aggred Forcas? 1 ☑ Yas 2 ☐ No If Yea, Give Yeer or Detes: Viet N		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or No Jerto Rican, etc.)	Specify	e - Americ ck, White, o		
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P hat the delay delay	F						10	Yss 2□ No	3 Prol	bebly 40 Unknown	
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DIVISION To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical C										
outhin outh	Z	29b. Signeture end title of certifier	18/1		29c. Licens			29d. Date signe			
FSFO		4	761		0.0	M.E.		Septemb	er 4,	1999	
		30. Name and address of person who	completed cause of death (Item 2	3a) (Type	Print)						
		David R F	mer			treet.	Baltimore	Marvl	and 2	21201	
	tate	31. Dete filed (Month, Dey, Year)	32. Registra s Signetur		1	1					
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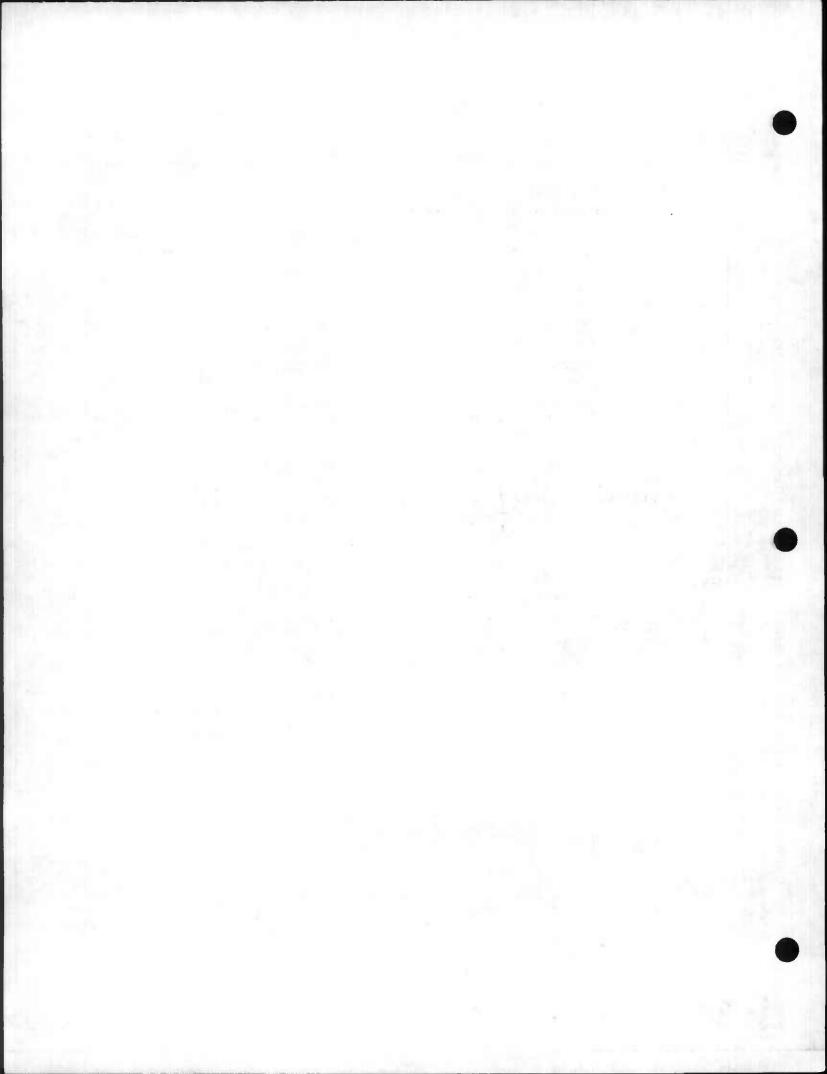
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year Month **Physician** ROBERT' SEPTEMBER 6, 1999 action of Death 4c. County of Death CARL LANDIS 10:00 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Data of Birth March 25,1945 7. Age (In yrs. last birthday) 54 yrs. 5. Social Security Number 9. Birthplaca (Stata or Foreign **Funeral** Months Days Hours 217-42-9629 NOM 2□ F Maryland Director Usual Residence of Decedent deeth with the Meryland 10a. Stata 10c. City, Town or Location worle 10b. County 10d. Insida City Limits r than "natural", or Nama 23a or 28a-f ehor Maryland Frederick Frederick 1X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 355 Monteuve Lane U.S.A. Funeral Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after nant of Health and Mertel hygiene. and if frem 27 is marked other than "natural", or health yor other that wate event, the Medical Estantically or other thatmatic event, the Medical Estantical by an original Estantical pages. 1XXVas 2 No 1963-1965 1X Never Married 2 Married aitimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 McClary William Landis Helen Elizabeth McKinley 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 1334 Taney Ave., Apt. 302, Frederick, Md. 21702 Mrs. Helen E. Landis, Mother 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Pege Department of Important: If eny injury or once. Smithsburg Crematory, Sept. 9, 1999 Smithsburg, Maryland 4 Donation 5 DOther (Specify) 22. Nama and Address of Facility Keeney and Basford P.A. Funeral Home 21. Signature of Funaçal Service License M00255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Intarval Batween Onset and Death Physician Immediata Causa (Final disease or condition rasulting in death) /Medical Examine Examine physicien and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence US0 88 0 signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Š 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? pega 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: director, 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. tnjury at Work? After 1 Natural 5 Pending ne Hospital or Attending n 24 hours after death. The Funeral Director: After pletaly filled in by the fur 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29c. License numbe 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) 32. Registra s Signatura

DHMH 16 Rev 6/95

State

Registrar

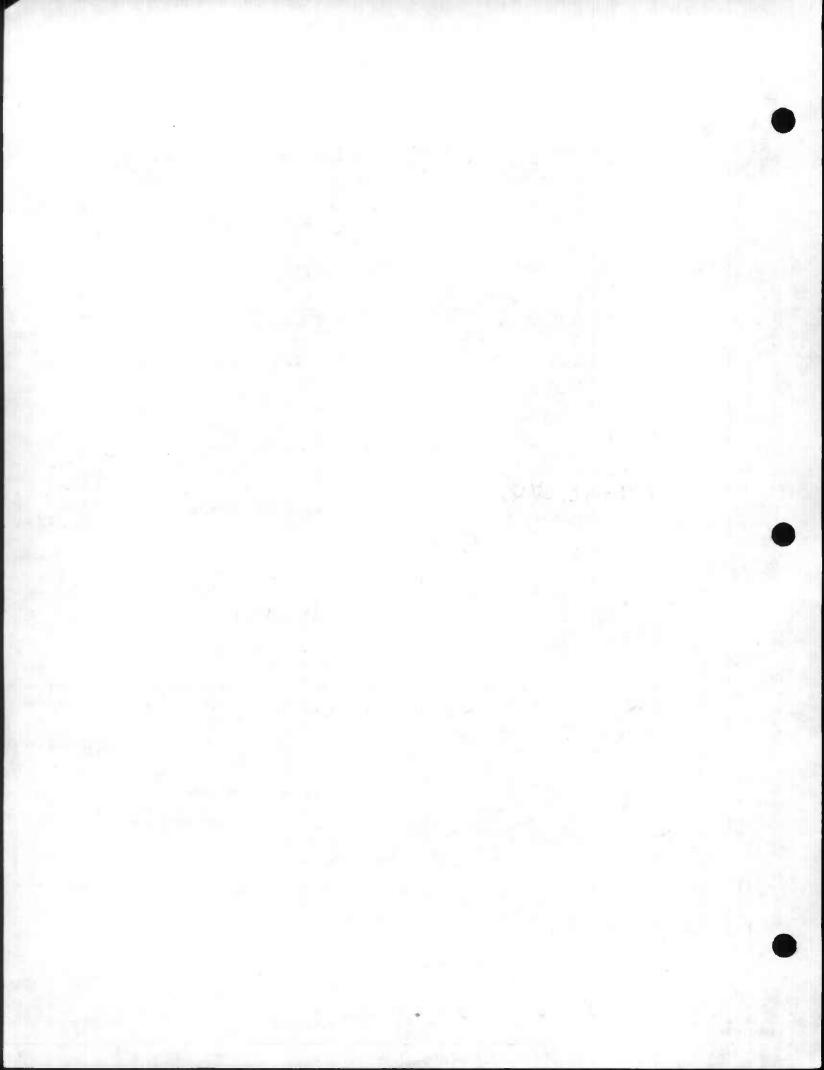
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sebtember 19,1999 **Physician** Latourette Joyce Ann 7:11 a.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 67 Yrs. 8. Date of Birth Month, Bay, Year 932 New York 6. Sex **Funeral** 104-24-4480 Days Hours 1□M 20F Director Usual Residence of Decedent West Va. 10c. City, Town or Location Berkeley Springs 10b. County 10d. tnside City Limits 28a-f show r than "naturel", or items 23s or 28s-f shorter Medical Examiner must be notified at Morgan 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Route 6 Box 12020 25411 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: if item 27 is marked other than ** any filury or other traumatic event, tra Med Phice. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Elizabeth Bert Wood Cook 2 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Gordon H. Latourette, Hubard Route 6 Box 12020, Berkeley Springs, W. Va. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory, Sept. 21, 1999 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximete Intervet Between Onset and Death **Physician** /Medical tmmediete Cause (Final disease or condition resulting in death) Examiner BOTH FEET Examiner sician and buriaf-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? RENAL 1118 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to Completed 24a. Was an eutopsy performed? completion of cause of death? 2 No Division of Vital Hospital or Attending Physicien: 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 2 Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier 14171 30. Name and address of person who completed cause of dgeth (Item 23e) (Type, Print) FREDERICK, MD 21702 THOMAS JOHNSON #203 WITE 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amended item#26, 9/7/99, FCHD KS 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Physician September 02, 1999
coation of Death 4c. County of Death Dennis Hamilton. Linthicum 3:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Deys 10XM 20 F 213-58-8748 Yrs. 1953 Maryland Director 46 Jan 11, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a notified at 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Barns 23a 21701 116 Frederick Avenue United States 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 72 hours after 1 Never Married 2 Married "natural", or white Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced il Hygiene. Il Hygiene. other than "natura rent, the Medical E. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Us Postal Service 12 Supervisor permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other trearmed overse 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles Hamilton Linthicum, Jr. Rose Mary King 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Linda Linthicum / wife 116 Frederick Avenue, Frederick, MD 21701 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Buriat 2 □ Cremation 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Grove Church Cem 9/5/99 Ijamsville, MD 21 Signature of Funeral Service Licenses 22. Name and Address of Fecility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pert1. Enter the disease, or complications that caused the data. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervet Betw **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical -5pi-460 Examiner Due to (or as e consequence of): Physician/Medical Examiner xtrasion physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. The law requires that the death certificate be Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24a. Wes an autopsy performed? 1□ Yes 2⊖No 1 Yes 2 No Amending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of Injury 28c. tnjury et Work? Certification: After Natural 2 Accident 5 Pending investigation 1 Yes 2 No To the Mospital or Atlandi within 24 hours after death. To the Funeral Director A completely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 114625 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20504 501

DHMH 15 Rev 6/95

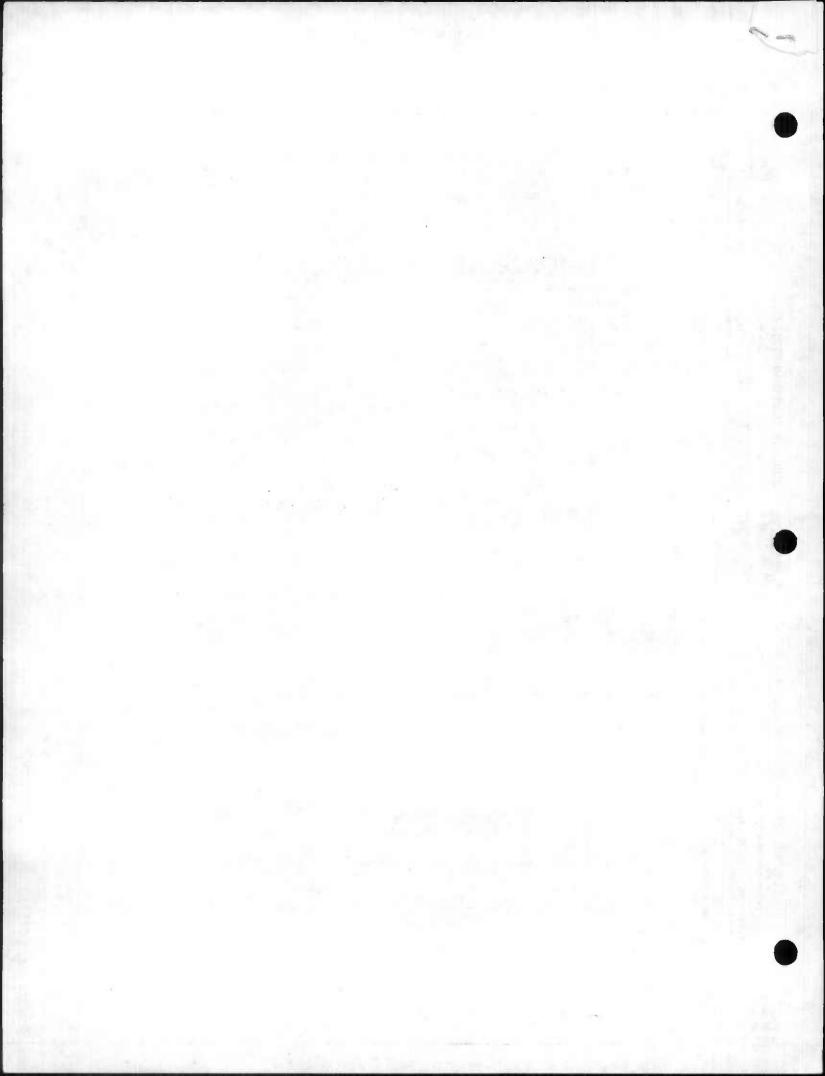
State

Registrar

31. Date filed (Month, Day, Year)

32. Registred Signature

1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey -INDSEY 22:24 MCELFRESH September 1999 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Hospi Balty W. . If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) (Month, Dey, Year) Catober 8, 1918 Baltimore Veterans Baltimore 5. Sociel Security Number 6. Sex 1 M 2 F If Under 1 Yeer . Age (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign Country) Maryland Deys Months 577-16-5616 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Maryland Worchester Ocean City 10e Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 21842 U.S.A. 5101 Coastal Highway - No. 11 12. Was Decedent Ever in U,S. Armed Forces? 1 Å Yes 2 □ No if Yes, Give Yeer or Detes: WWII 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Builder Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Hughsie McElfresh Sophronia Burdette 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21842 19a. Informent's Name/Relationship (Type, Print) Virginia B. McElfresh - Wife 5101 Costal Highway - No. 11, Ocean City, Maryland 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete ₩ Burial 2 Cremetion 3 Removal from State Damascus Methodist Cemetery 9/5/99 4 ☐ Donetion 5 ☐ Other (Specify) Damascus, Maryalnd 22. Name end Address of Fecility 21 Signeture of Funeral Service Licenses Olin L. Molesworth P.A., Funeral Home 20872-0117 Approximate Interval Between Onset and Deeth 26401 Ridge Road, Damascus, Maryland one that caused the deeth. Do not e Endocarditis Pseudomonas Immediate Cause (Final disease or condition resulting in deeth) rosthetic Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Was en eutopsy 1 Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) AOG DI

Physician /Medical Examiner

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Division of Vital Records. P.O.

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r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at

the Meryland

death with

permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite

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injury or

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☐ 10	Hospitel: Unpatient 2	≥ ☐ ER/Outpetient	3
27. Manner of Deeth 1. Neturel 5 Pending	28e. Dete of Injury (Month, Dey Year		

28c. Injury et Work? 28d. Describe how injury occurred Dete of Injury (Month, Dey Year)

1 Yes 2 No

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

(Check only one)

2 Accident

3 Suicide

29a. Certifier

4 Homicide

🕊 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Dete signed (Month, Day, Year) 29c. License number

29b. Signeture end title of certifier

investigetion

6 Could not be determined

P11627

September 1, 1999

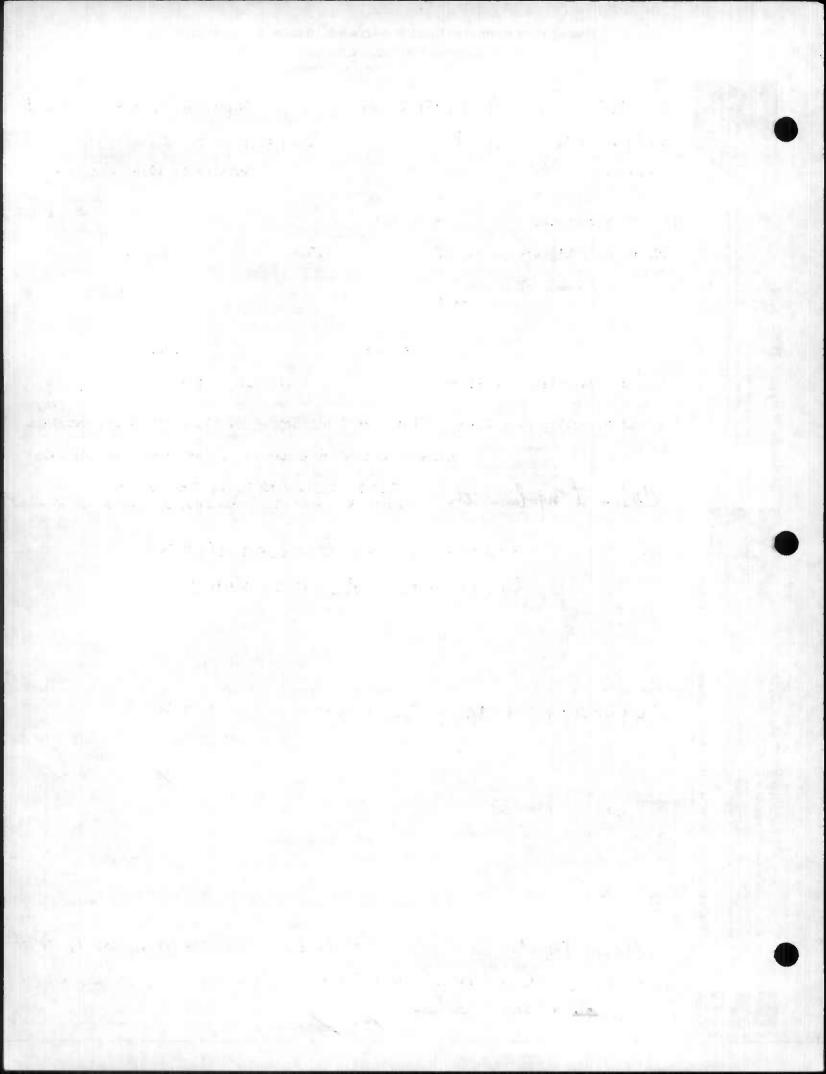
30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

MARYland 22 S. Greenestr. Baltimore MD 21201 University of

State Registrar

32. Registrer's signeture 1999

B. Aparle



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death September 14, 1999 **Physician** Daniel Wilson McCallum 9:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northampton Manor Nursing Center Frederick Frederick 5. Social Security Number 578-14-3972 If Under 1 Year | If Under 24 Hrs. Birthplace (Stata or Foraign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Dala of Birth (Month, Day, Year) **Funeral** Months Days Hours 10XM 20 F Director Nov 20, 1921 Washington, Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Merylan neat of Health and Mertal Hygiene.

Mrt. If from 27 Is marked other than "natural", or from 23s or 28s-1 show that if it is not a marked other than "natural per notified at any or other traumatic event, the Medical Example mast be notified at Maryland Frederick Frederick XXYes 2 No **Funeral Director** 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5681 Barberry Court 21703 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. NOYes 2 No If Yes, Give 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: White Specify: by 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Information Specialist Federal Government Baltimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Wilson McCallum Sr Jane Patricia Halloran 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Mrs. Adelaide L. McCallum/Wife 5681 Barberry Court, Frederick, Maryland 21703 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. St. John's Cemetery Sep 18,1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licenses 106 East Church St, Frederick, Maryland atthr M00706 21701 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical month Examiner month Examiner ec+ 40 sician and burial-transit The lew requires that the deeth certificata be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the burial Box 68760, Physician/Medicai Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Certification: To Be Completed 1 Yes W No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes PNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of tnjury (Month, Day Year) funerel 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending Netural 5 Pending investigation • Funeral Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital edical 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mainter as stated.
Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c, License number 29b. Signatury and little of certifier 29d. Date signed (Month, Day, Year) 51643 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren Shah, M.D., 170 Thomas Johnson Drive, Suite #100, Frederick, Maryland 21702

DHMH 16 Rev 6/95

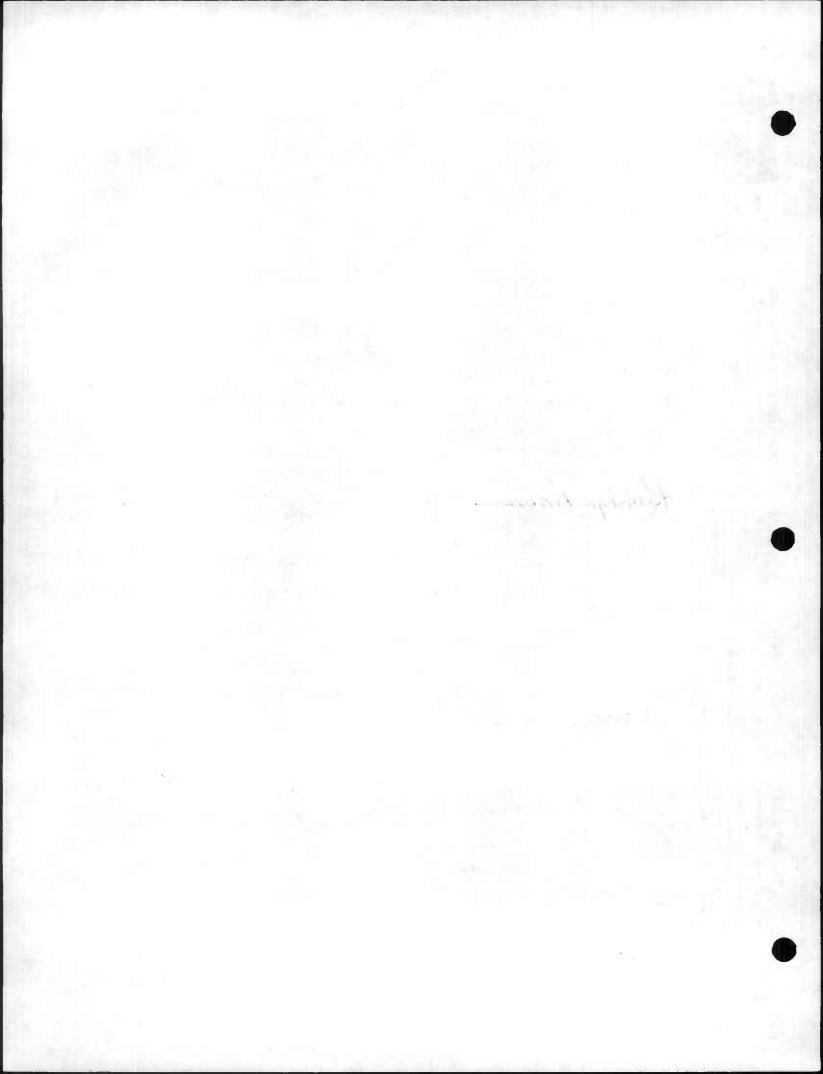
State

Registrar

31. Date filed (Month, Day, Year)

32. Registrare Signeture

SEP 1 6 1999 >



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death FCHD, KS Amended item#1, per doctor, 9/22/99 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey September 14 **Physician** 1999 12:35 AM Jean Moyers Alice /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | 9. Birthplaca (State of Birth (Month, Day, Year) | Birthplaca (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2☑F 217-32-6105 Director Usual Residence of Decedent 10c. City, Town or Location 10s. State 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show MYes 2□No Director Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 West "B" Street 21716 USA permit. Pegas 1 end 2 should be filed within 72 hours after deeth v Department of Health end Mentel Hygiene. Important: If itsm 27 is marked other than "netural", or itema 23a ent hijury or other traumatic event, the Medical Examines must poles. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Geographic Elementary/Secondary (0-12) College (1-4or 5+) Analysist Society 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frances Catherine Williams Virgil Moyers 2 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Central Avenue, Brunswick, MD 21716 Betty L. Brooks, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Buriat 2 Cremation 3 Removel from State Brownsville Heights Cemetery 9/16 Brownsville, MD 4 ☐ Dgnation 5 ☐ Other (Specify) Filtres Service Lighteen Will 22. Name and Address of Facility
John T. Williams Funeral Home Barbara A. Williams, Owner 100 Petersville Rd., Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Daath **Physician** Pancreatic Carcinoma /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Examiner ician and buriel-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burie Physician/Medical Due to (or as e consequence of): 8 ate has been signed by the a page 2 should be detached? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown à Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 8 26. Place of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

Box 68760. P.O. Records, Division of Vital or Attanding Physician: funeral director, After this Hospital or Attanding
 24 hours after deeth.
 Funeral Director: After filled in by To the Hosp within 24 ho To the Fune completely fi

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier

(Check only one) 29b. Signature and title of contiling MI

29d. Date signed (Month, Day, Year) 29c. License number Sept. 14, 1999

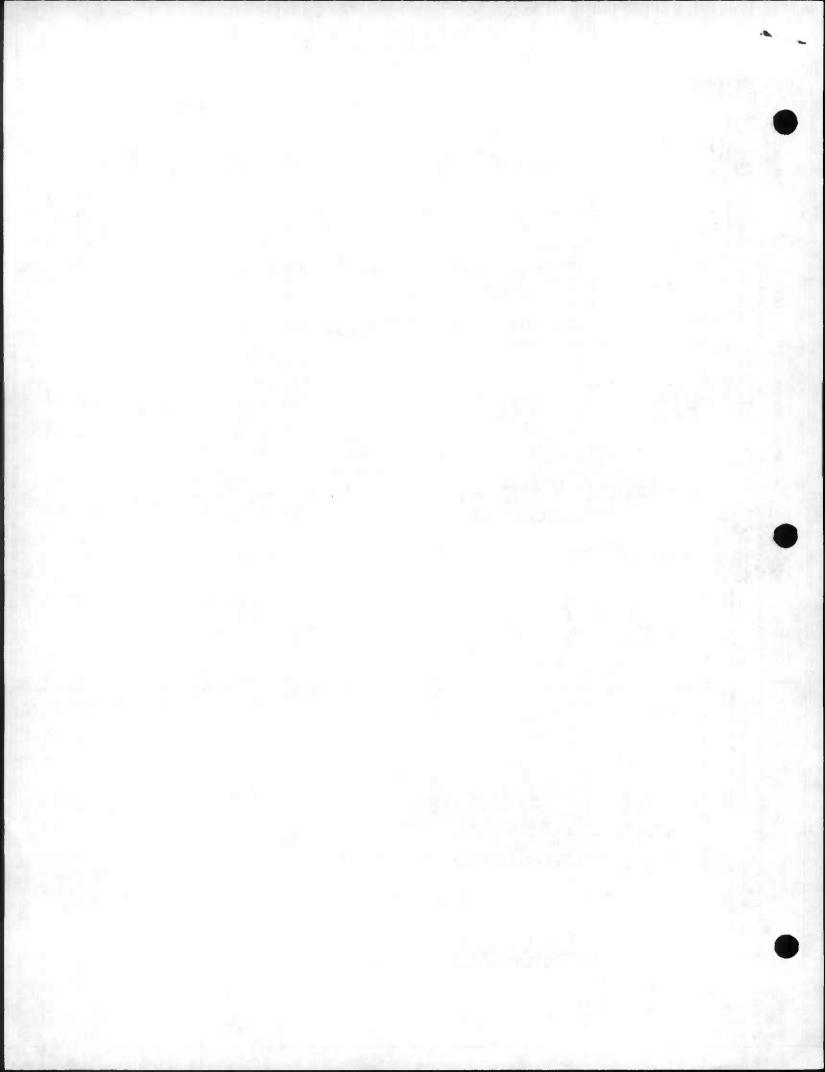
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick MD 21701 w 7th Elhamy Eskander MD 501

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Re **SEP 1 5 1999** 32. Registrant Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** Rosa Bethel Moss September 26, 1999 3:15 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Dey, Year)
Oct. 7, 1895 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Months 212-54-6376 1 M 2 VF 103 Virginia Director Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. tnside City Limits Maryland Frederick Frederick 1 Yas 2X No Director 28s-f 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? b 6898 Crabapple Court 21703 U.S.A. 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) thems: 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 27 TNo tt Yas, Give Yaer or Detas: 14. Race - Amarican Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 ☐ Yas XX No Specify: Specify: White à 3 X Widowed 4 □ Divorced 'natural'. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast greda complated) 16b. Kind of Business/Industry Hygiece. Elamentary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mothar's Nema (First, Middle, Maiden Sumama) 17. Father's Nama (First, Middle, Last) Be Pages 1 and 2 should be 1 sent of Health and Mental I int: If Item 27 is marked of John Henry Shorter Kate Ann Durham 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. tnformant's Name/Raletionship (Type, Print) Mrs. Barbara A. Wheatley, Daughter 6898 Crabapple Court, Frederick, Maryland 21703 important: If Itam 27 any injury or other 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 🛛 Cramation 3 ☐ Removal from State Smithsburg Crematory, Sept. 27, 1999 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensea 22. Nama and Addrass of Facility Keeney and Basford P.A. Funeral Home M00255 23a. Part1. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. 21701 Approximate Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final PNELMON, A 3 DAYS disaase or condition rasulting in daath) Examine Dua to (or as a consequence of): Examiner HIP 13 DAYS FRACTURE physician and s the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Causa (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I 235. Did tobacco use contribute to the cause of death? Records, P.O. 1 Ses 2 No 3 Probably 4 Unknown by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed 1 Yas 2 No 1 ☐ Yes 2 No Division of Vital Attending Physician: 25. Was casa refarred to medicat axaminar? Be 26. Place of Death (Check only ona) 1 Yas 2□ No Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Deta of Injury (Month, Day Year) After 1 Natural 5 Pending FELL AT HOME death. Invastigation 1 Yas 2 XNo To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu 4:00 PM 2 Accidant 3 Suicida 9/13/99 6 Could not be datamined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 2170/ 28a. Place of injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicida 6898 CRABAPPLE CT. HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signatura and titla of certifiar 29c. License number 9/27/99 Indraw O. Donilian = D21936

State Registrar

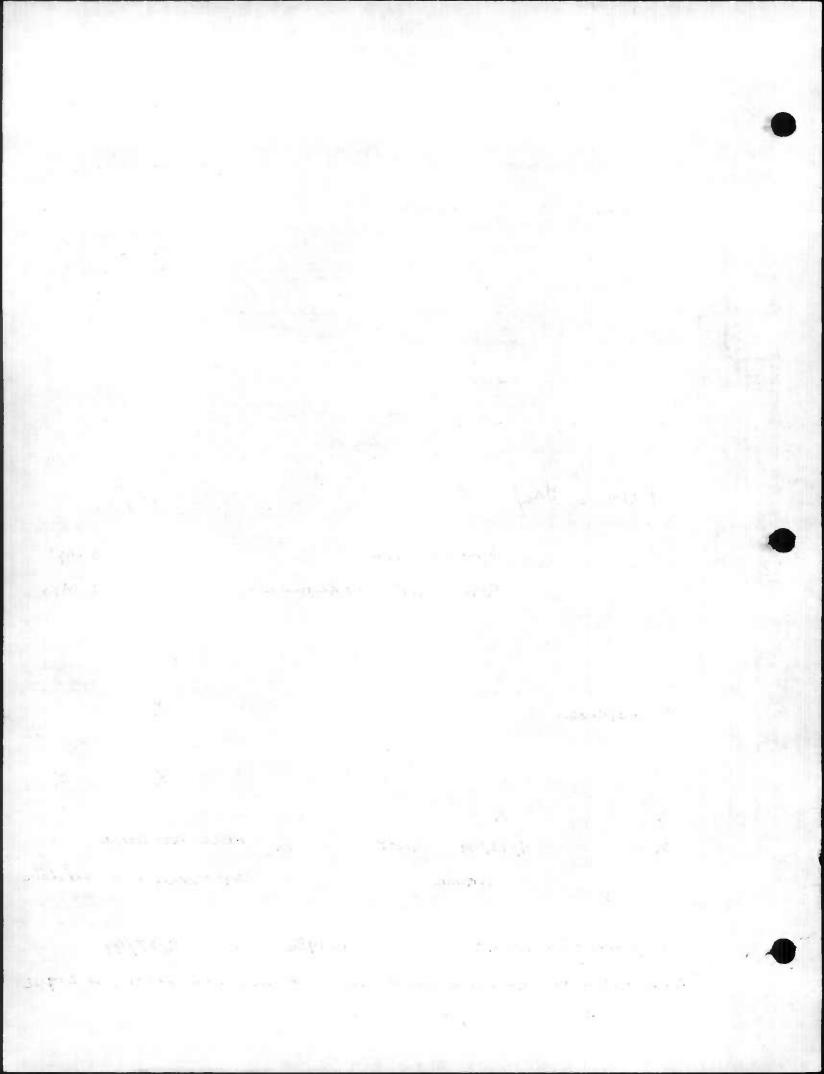
170 THOMAS WOHNSON DR., STUTE 100, 31. Data filed (Month, Day, Year) 2.8 32. Registrar's Signatura 1999

30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print)

A. DONELSON, MO

Sparks

FREDERICK, Mg 21702



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** L015 Month reptember 14 1999 /Medical 4a. Fecility Nema (If not institution, giva street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital City Baltimore H Undar 24 Hrs.
Hours Min.

B. Data of Birth (Month, Day, Year)
Dec. 29, 1908 If Under 1 Year 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1 □ M 2 1 F Director 214-40-6014 90 Yrs. Montana Usual Rasidanca of Daceden the Marylend 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show ther must be notified at 1 ¥ Yas 2 No Director Maryland City Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21239 5702 Loch Raven Blvd. United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑No If Yas, Giva Yaar or Datas: Wes Dacedant of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, treumstic event, the Medical Examiner Bieck. Whita, etc. filed within 72 hours efter 1 Never Married 2 Married altimore, Maryland 21215-0020 ò 1 Yas 2 No Specify: þ Specify: 3 Widowad 4 Divorcad White "naturel", Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grade complated) end 2 should be filed within ealth end Mental Hygiene. n 27 ie marked other than Eiamantary/Secondary (0-12) Coliega (1-4or 5+) 11 Librarian City Library 17. Fethar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Robert J. Northern Ellen Giffor 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2: Department of Health er Important: If item 27 ie eny injury or other treu Niece 25909 Ridge Manor Drive, Apt. N Damascus, Md 20872 Marion Northern/ 20b. Piace of Disposition (Nama of cematary, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramovai from State 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematorium Inc9/16 Alexandria, Virginia 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23e. Pert1. Enter the disaesa, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. **Physician** Myocardial Infarction /Medical Immediata Cause (Final diseese or condition resulting in daath) **Examiner** 'ardiovancular de xae Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Diseese or injury that initiated avents resulting in daath) Lest and Denurle Box 68760, Physician/Medicai Due to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? signed by t 4 Unknown 1 Yss 2 No 3 Probably Records, þ Be Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings evailable prior to completion of cause of death? ate hes certificate Division of Vital the Hospital or Attending Physician: 'hin 24 hours efter death.
the Funeral Director: After this certifica mpletely filled in by the funeral director; p 25. Was casa rafarred to madical 26. Piaca of Daath (Check only ona) 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accidant 5 Panding invastigation 1 Yas 2 No 3 Suicida 6 Could not be determined 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 28e. Pieca of Injury - At homa, tarm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral D completely filled 29a. Certifiar Cartifying Physician: To tha best of my knowledga, daath occurred at the time, data and placa, and due to the cause(s) end mennar as stated.

2 Medical Examiner: On tha basis of examinetion end/or invastigation, in my opinion, death occurred et tha tima, data and placa, and dua to the cause(s) and mannar statad. 29b. Signatura and title of certifiar 29d. Dete signed (Month, Day, Year) 29c. Licanse number 30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Pript) W. Ev taw St BANAMA JU176 308 AMESH

32. Ragistrari Signetura

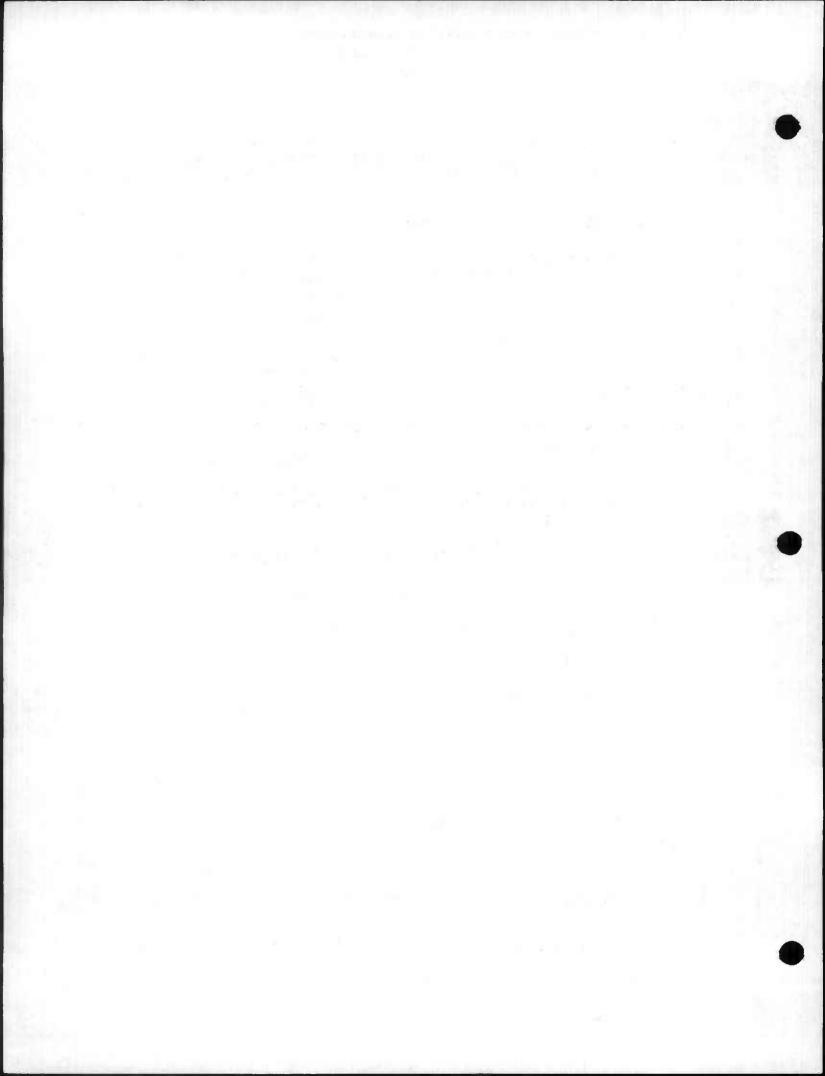
DHMH 16 Ray 6/95

State

Registrar

31. Deta filed (Month, Day, Year)

SEP 1 7 1999



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death September 8, 1999 Year **Physician** 7:40 AM William Melvin PAGE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Frederick Frederick Northampton Manor Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 80 Yrs. 8. Data of Birth (Month, Day Year) Oct. 29, 1918 Washington, DC **Funeral** Hours Days 215-36-6808 1 M 2 □ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick 1 Yas 2 No Maryland Buckeystown Director 280-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or itsms 23s or 6912 Michaels Mill Road 21717 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oths any Injury or other traumatic event abos. Be Joseph William PAGE Nellie. COUGHLIN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Susanne E. Blank, Daughter P.O. Box 31, Buckeystown, Maryland 21717 20a. Mathod of Disposition

12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cematery, cremetory or other place) Data 20c. Location - City or Town, State Mount Olivet Cemetery, Sept. 11, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M00255 **Physician** /Medical Immediate Cause (Final accident erehro outcul disaasa or condition resulting in death) Examiner Examiner physicien and the burial-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d 1 Yes 2 No 3 Probably 4 Unknown monocytic leutremin à 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate 1 Tyes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yas 2 Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 8141 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After **Dalural** 24 hours after deeth. 1 Yes 2 No 2 Accident

P.O. Box 68760. Records, Division of Vitai

To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

5 Pending invastigation

6 Could not be detarmined

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Certifying Physician: To the best of my knowledga, death occurred at the tima, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifier

3 Suicide

29a. Certifier

29c. License number

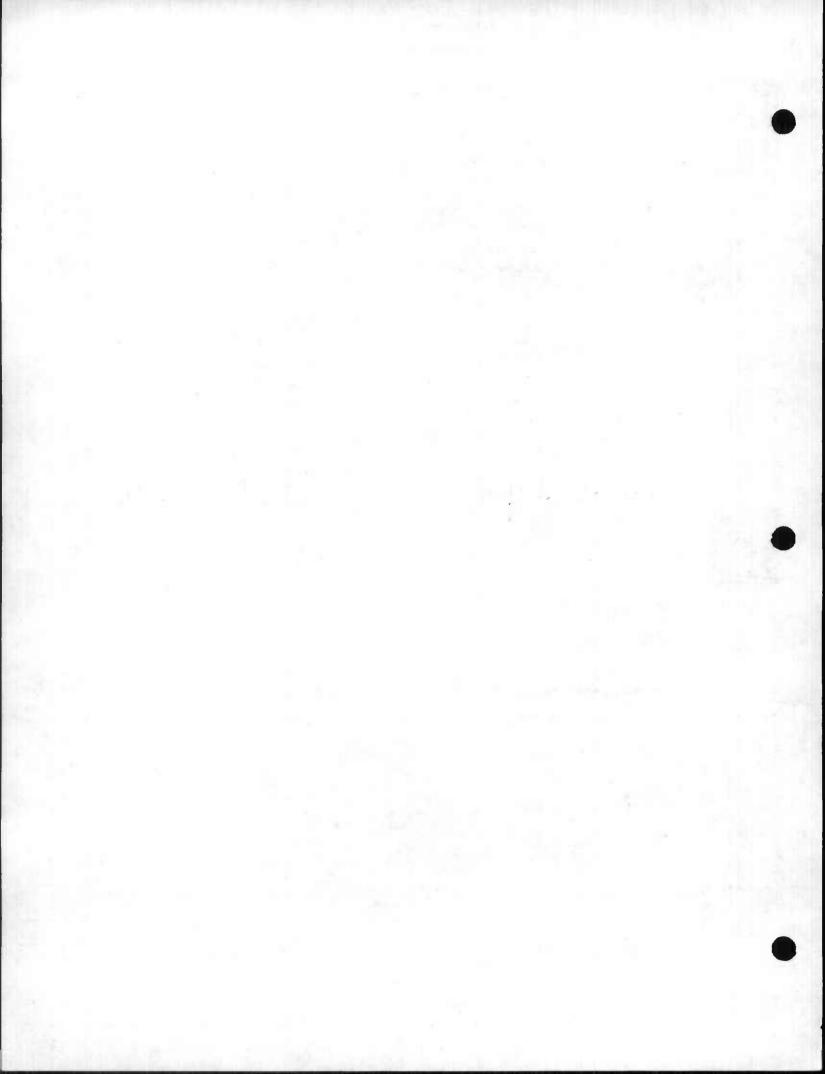
29d. Data signed (Month, Day, Year) September 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 W M.D. 31. Date filed (Month, DS)

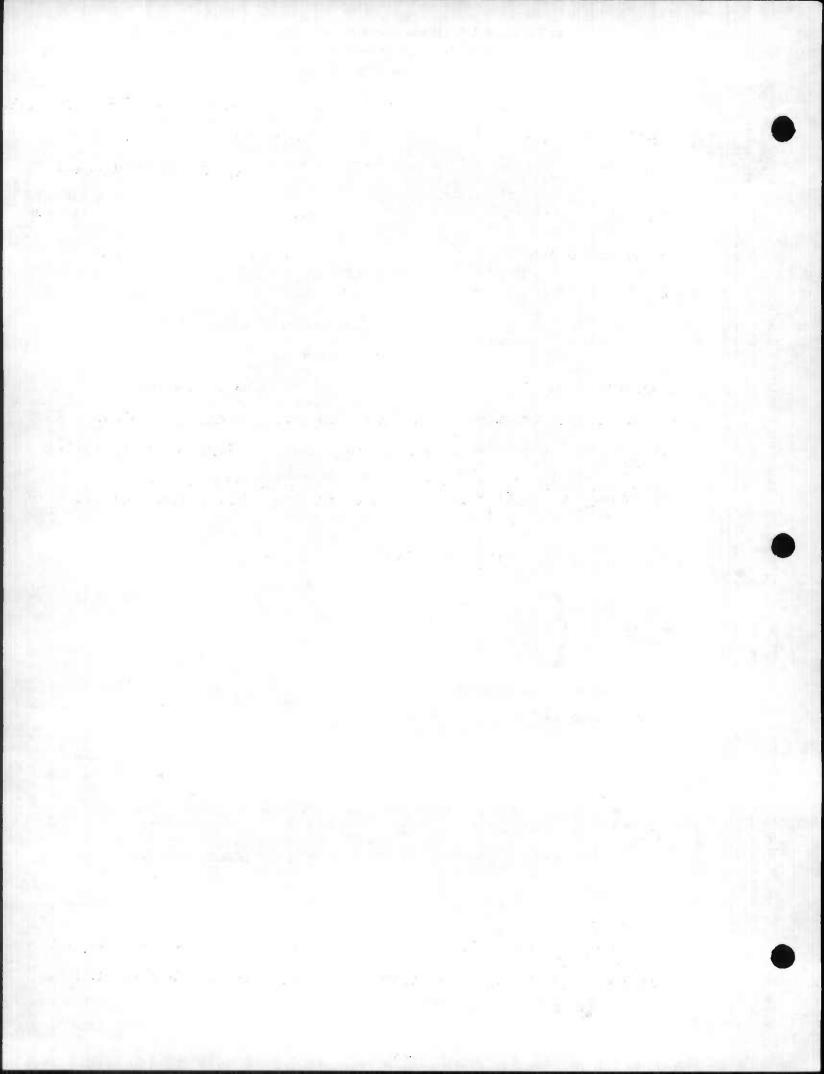
FREDERICK MD. 21701

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 3 | 8 |

					Ce	rtificat	e of	Death			Reg. No.		
Physician /Medical Examiner		1. Decedent's Neme (First, Middle	120	Poole, Jr.				2. Dete of Deeth Month Down Year 3. Time of Deeth					
		Charles	F					September 14, 1999			3:30 P.		
		4e Facility Name (If not institution, give street end number) 4639 Ed McClain Road				4b. City, Town, or Lo Monrov							rick
Funeral Director		5. Social Security Number 215-88-8226	6. Sex 1X M 2□		. last birthday) Yrs.	If Under Months	1 Year Deys	Hours	Min.	8. Date of Bir (Month, De May 17,	y, Year) 1936	9. Birthple Count Mar	ace (Stete or Foreign ry) yland
pue *	-	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10	Od. Inside City Limits
e Maryle			rederic				lonr	ovia			<u> </u>		1 ☐ Yes 2 🛣 No
th with th	ai Dire	10e. Street and Number 4639 Ed McClain	Road			10f. Zip Code 21.770					10g. Citizen of What Country? U.S.A.		
urs e	by Funeral Director	11. Maritel Status 1 ☑ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	led 1 TY	Decedent Ever in 1 Forces? es 2 No , Give or Dates:		Wes Deced If Yes, spec		lispenic Orig an, Mexicen Specify:	gin? (Sp , Puerto	ecify Yes or No Ricen, etc.)	- 14. Re Bla Specia	ce - America ick, White, e fy: Whi	etc.
in 72 ho n *natur	Completed	15. Deceden (Specify only highes	at grede complet		(Give	dent's Usua kind of wo DO NOT us	rk done	during most	of work	ing	16b. Kind of B	Business/Ind	ustry
77 77 10 77	ошо	Elementery/Secondary (0-12)	Colleg	ge (1-4or 5+)		Never	wo.	rked					
other other	Be C	17. Father's Neme (First, Middle,	Last)			11000			r's Nem	e (First, Middle	Meiden Sumer	me)	
should by and marked imatic av	0	Charles H. Poo	le, Sr.						Ed	na Mae	Cashour		
nd 2 sith er		19e. Informent's Name/Reletions Raymond M. Poo		her							e, Md.		Code)
90=5		20e. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)	3 □Removal fr	om Stete Pro	Plece of Disponents of Comptents psition (Ner metory or o Leme to	ne of ther ple Ery	Sept.	. 18	, 1999	20c. Location Mt. Ai	- City or Tov	m, Stete aryland	
permit. Pa Departmen Important: any injury ance.	-	21. Signature of Funeral Service		sh MOO	021					Funera		rick 1	Md. 21701
	+	23a. Pert1. Enter the diseese, or shock, or heart feilure. List	complications th	net a used the dec	eth. Do not en							ICK,	Approximete Intervel Between
ita be iyslcia na bur	0	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest	b	Due to	(or es e consector as a consector as	quence of):							
ding ding	ian/Me		d										
	Physician	Pert II. Other significant condition	Λ	to death but not re	sulting in the u	inderlying o	ause gi	ven in Pert I			Yes 2 No		the cause of death?
gne d	þ	Seizure Disor	der							24e. Wes	en eutopsy		ere eutopsy tindings
blaw has b	Completed									10		cor of o	npletion of cause deeth?
F to d	0	25. Wes cese referred of medical						26 Place	of Deet	th (Check only)			7165 20110
	0	axeminer? 1 ☐ Yes 2 ☑ No	Hoepital:	□ Inpetient 2	☐ ER/Outpetie	nt 3 D	OA Ott	nor:	rsing Ho		dence 6 □Ot	her (Specify	1)
ding Physith. After this funeral di									how injury occu	rred			
l or Attending after death. Director: Afte d in by the fune	Certification:	2 Accident 3 Sulcide 4 Homicide	not be 28e. P	lece of Injury - At uilding, etc. (Spec	home, ferm, st	reet, fector	y, office			28f. Location (City or To	Street and Num wn, Stete)	ber or Rure	l Route Number,
		29e. Certifier 1 Certifyin (Check only one)	Examiner: On the	the best of my kr ne basis of examir menner steted.	nowledge, deat netion end/or in	h occurred evestigetion	et the ti	me, dete en oplnion, dee	d plece, th occur	end due to the red et the time,	ceuse(s) end m	nenner es st , and due to	eted. the ceuse(s)
o the o the o the		29b. Signature and time certifie		A STOREGO.		29	c. Licens	se number			29d. Date sign	ed (Month, i	Dey, Year)
F 3 F 8		1 /1/201	1.1111	ban				D4030	07		Septem	ber 1	5, 1999
	-	30. Neme end eddress of persony	who completed	ceuse of deeth (Ite	em 23e) (Type,	Print)	วพา			derick.	-		
		Eugene Casag				L	> WII						
Stat Registra	.6	SEP	7 1999	2. Registra	X	10.	10	park	2				

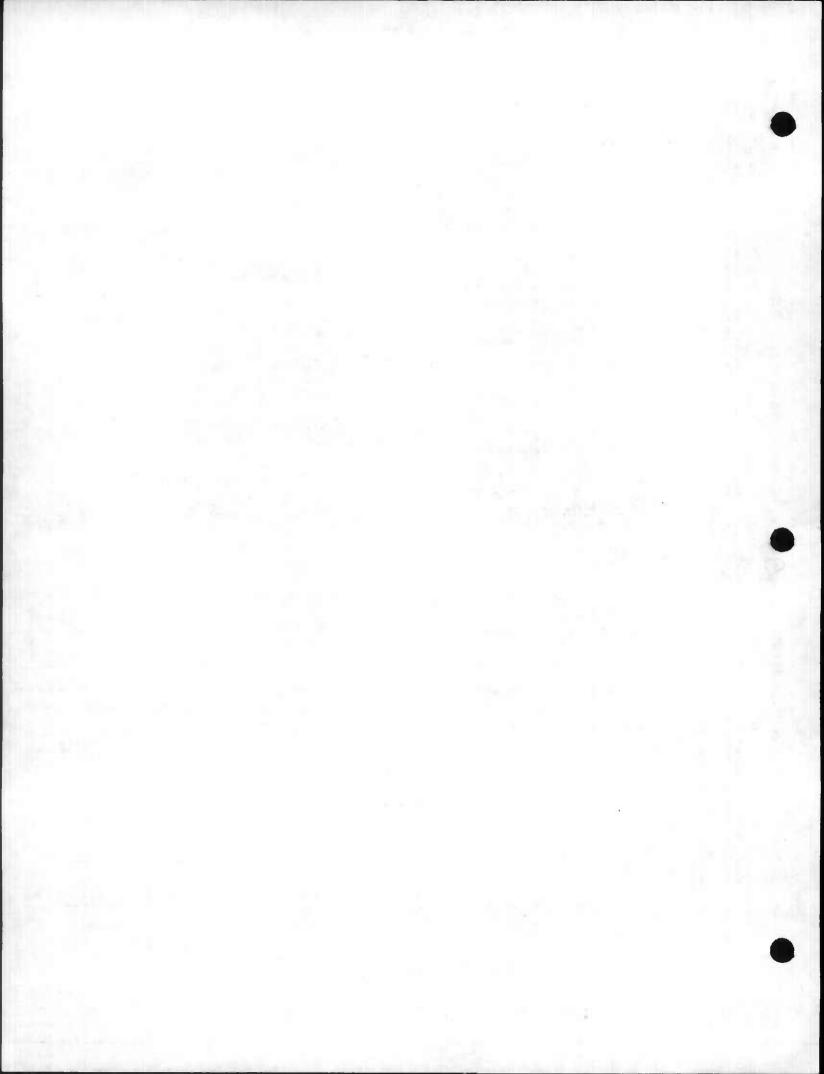


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey **Physician** Walter Robert Ramsburg September 6, 1999 5:30 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Frederick Health Care Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (Ste Country) April 5, 1924 Maryland 5. Sociel Security Number Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 10 M 2□ F Yrs. Director 212-24-0213-A 75 Usuet Residence of Decedent r 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Frederick Woodsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number flerns 23a or 21798 United States 10 Rosewood Court, Unit 101 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 72 hours after 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No If Yes, Give Baitimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: specity: white P 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "nat, any injury or other traumatic event, the Medical page. Elementery/Secondery (0-12) College (1-4or 5+) Proprietor Electrical 18. Mother's Neme (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) Be Allen B. Ramsburg Lillie Stull 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mary Alice Ramsburg/ wife 10 Rosewood Ct., #101, Woodsboro, MD 21798 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 9/9/99 Walkersville, MD Glade Cemetery 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Stauffer Funeral Homes, P.A. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or need feiture. List only one cause on each line. 40 Fulton Ave., Walkersville, Maryland 21793 Approximate Interval Between Onset and Death **Physician** fmmediate Ceuse (Final diseese or condition resulting in deeth) /Medical . CARCINOMATOSIS WEEKS Examiner Examiner YEARS CARCINOMA attending physician and for use as the bunal-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or es e consequence of): .88 23h. Did tobacco use contribute to the cause of death? P.O. Pert If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, Á 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? Completed certificata has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this cardifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2 No 10 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred edical Certification: 5 Pending investigation 1 Neturat 1 Yes 2 No NA 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted. 29e. Certifier (Check only one) 29b. Signature any other of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D 18063 MD 30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print) AUE FREDERICE MU 2/201 801 TOU HOUSE MASERD 31. Dete filed (Month, Dey: Year) . Registrar's Signeture State

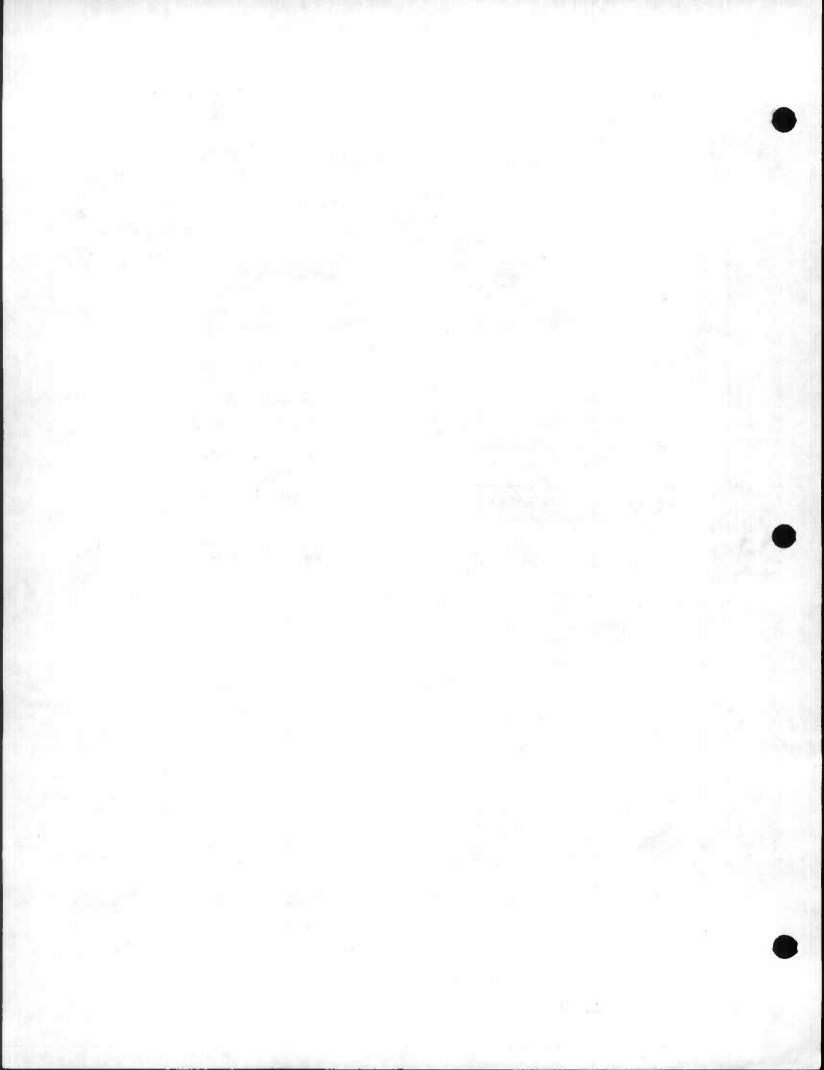
DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ida September 26,1999 Rovin 11:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (În yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Hours Yrs 90 Director 218-24-1365 Dec. 11,1908 Usual Rasidance of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Wastral Examination Instituted Institute 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1508 W. Tenth St. 21701 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indien, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Clothing Shop 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 Isadore Zelditch Hannah Marshall 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonya Alperstein / daughter 3 Jenny Lane / Pikesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Resthaven Memorial 9-27-99 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funerel Servica Licensee 23a. Part 1 After the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocl or heart failure. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, MD 21702 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 20 Minuter Examiner The law requires that the deeth certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Penal Disease ate hes been signed page 2 should be de Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Oster an thritis of Cervical spine 200 No 1 Yes 20 No 1 ☐ Yes certificate Division of Vital Hospital or Attending Physician: 24 hours after death.
 Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yas 2 No Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) the th 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 2 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TollHouse Ave. / Frederick, MD 21701 Phillip Shapiro, 31. Date filed (Month, Day, Year) 32. Registrar Signature State SEP 2 8 1999 > Spark Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Robinson 615P Grenaldine 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth ounty Hospital Olymbia Howard Crenoval If Under 24 Hrs. H Under 1 Year 8. Date of Birth (Month, Day, Oct 19 Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Year) 1934 Hours Months 1□M 25 F Yrs. KY 337-30-7554 64 Oct Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1€ Yes 2 No MD Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19103 Wootton Ave. 20837 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forces? 14. Race - Amarican Indian, Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Housewife Domestic 6 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John D. Wells Nancy Blanton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 19e. Informant's Neme/Retationship (Type, Print) Patricia Masden/daughter 21701 Club Hollow Rd., Poolesville, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removal from State 9/20 Resthaven Cemetery Frederick, Md 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Hilton Funeral Home Barnesville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death lung ancer Immediate Cause (Final 6 Mouths disaase or condition resulting in death) Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings aveilable prior to completion of causa of deeth? 24a. Was en eutopsy Vaccular Disease 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner Examiner

sicien and buriel-transit

Physician/Medical

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Completed

Be

Medical Certification: To

The law requires that the death certificate be executed

P.O. Box 68760.

Records.

Division of Vital

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific

within 24 hours after de To the Funeral Directo completaly filled in by th

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Physician

/Medical

Examiner

Director

Funeral

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Completed

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rithen "natural", or items 23s or 28s-f shore

permit. Pages 1 and 2 should be filed within 72 hours after of Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, trailed and entered

Baltimore, Maryland 21215-0020

the Maryland

death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disees or Injury that initiated events resulting in deeth) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. leviphera

25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 ☐ Yes 20 No Hospital: 12 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of

28e. Date of Injury (Month, Dev Year) 28c. Injury at Work? 1 Naturat 5 Pending 1 Yes 2 No 2 Accident investigetion

6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of tnjury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner es stated.

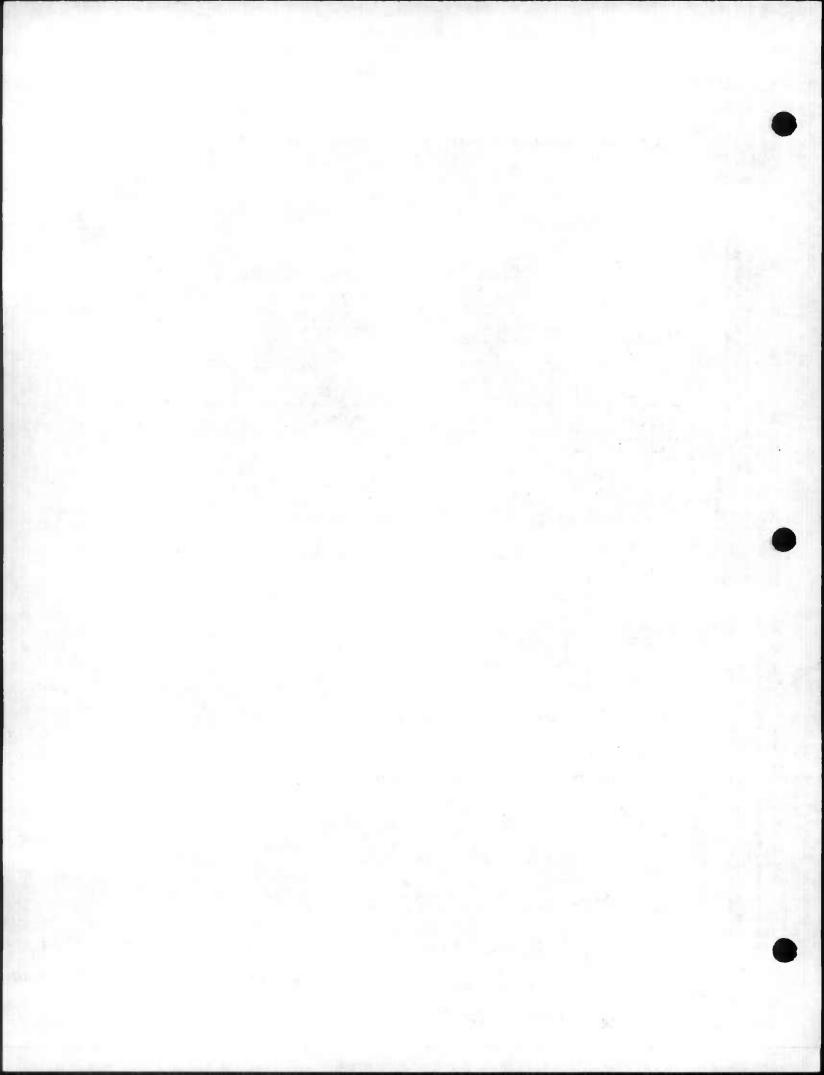
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier

29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar

DOO 52940 . Sha MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

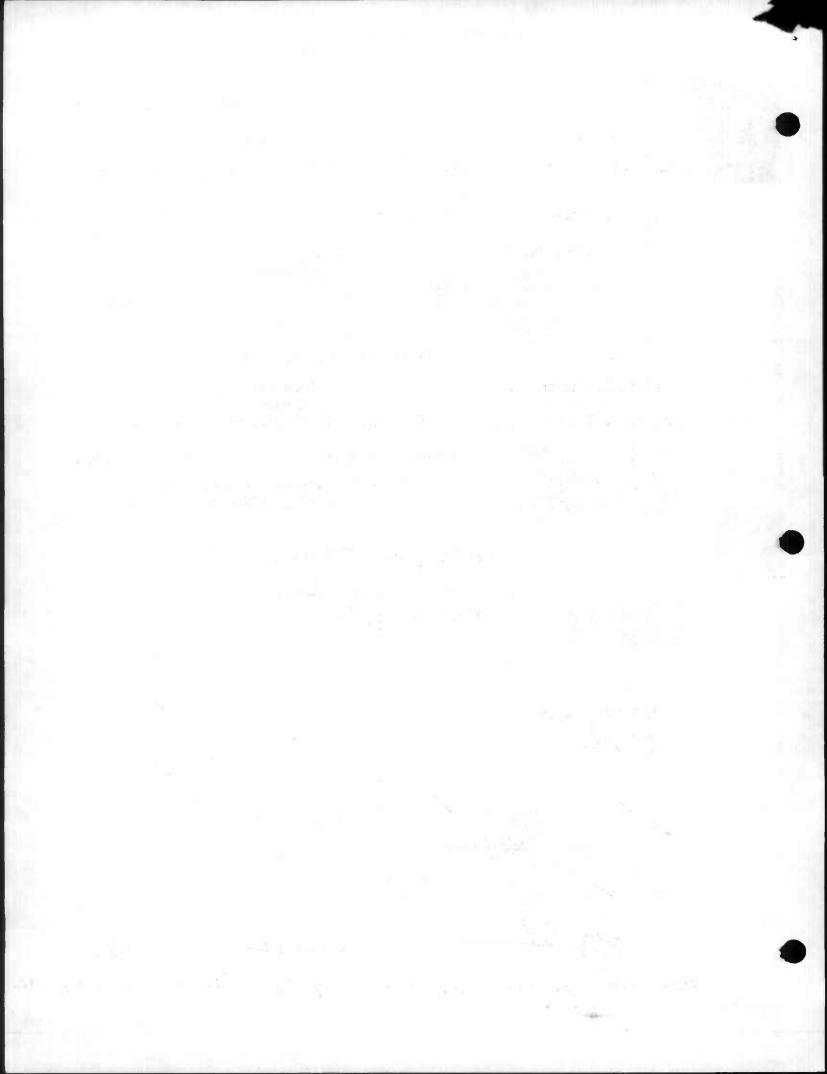
Columbia, MD21044 SHAH, MD 10805 Hickory Ridge #210. 31. Data filed (Month, Day, Year)



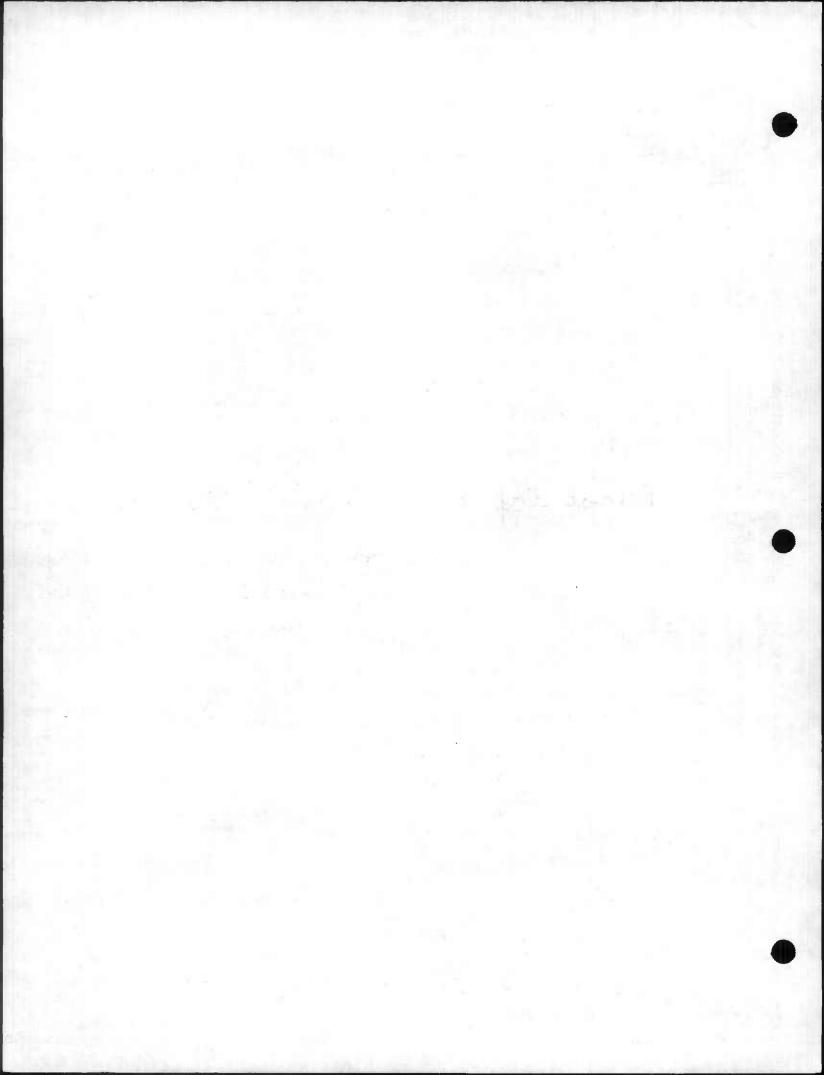
State of Maryland / Department of Health and Mental Hygiene

Amended item#28a,31 per doctor 9/8/Gertificate of Death FCHD.KS 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** August 31, 1999 Merhle Donald Shafer 9:30 AM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Hours Min. 8. Date of Birth (Month, Dev. Year) 1930 If Undar 1 Yaar 5. Sociel Sacurity Number Birthplaca (Stata or Foreign Country)
 MD 7. Aga (In yrs. lest birthdey) **Funeral** Days MXM 2□ F Yrs Director 213-24-8030 69 Usuel Residence of Decedent death with the Maryland 10e Stata 10h Counts 10c. City, Town or Location 10d. Inside City Limits must be notified at MD. Frederick Middletown Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7716 Picnic Woods Rd. 21769 U.S.A. 12. Was Decedent Ever in U.S. Armad Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, r than "naturel", or Item the Medical Examiner NO Yes 2 No 1951— If Yes, Give Yaar or Dates: 1953 Black, White, atc. filed within 72 hours after 1 ☐ Never Married ♣ Married 21215-0020 þ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: If item 27 is marked other than iry or other traumatic event, the M. Elementery/Secondary (0-12) College (1-4or 5+) 12 maintenace plant operator federal gov't. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Calvin P. Shafer Sr. Lora Beachley 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stete, Zip Code) Shirley M. Shafer (Wife) 7716 Picnic Woods Rd., Middletown, MD. 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any Injury or 9/4 Reformed Cemetery 4 □ Donation 5 □ Other (Spacify) Middletown, MD. dre of Funeral S 22. Name and Address of Facility Donald B. Thompson Funeral Home 21769 31 E. Main St., Middletown, MD. 23a. Part 1. Entar the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List pnly one cause on each lina. Approximate Interval Between Onsat and Death **Physician** /Medical Immediata Ceuse (Finel disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediata causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) Part it. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? in compliance 1 ☐ Yee 2 ☐No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings eveileble prior to Be Completed 24a. Wes en eutopsy performed? completion of cause of death? certificate has 2 No 1 Tas 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stete) 4 I Homicida 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Cartifian Medicai completely 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 50822 son who complated cause of death (Itam 23a) (Type, Print) 11110 medical Compus Rd. Ste#107 Hagerstown, md 21742 Neal Partalinghug mo 31. Date filed (Month, Day, Yeer) 32. F 32. Registrar's Signature 8 1999 N State Registrar

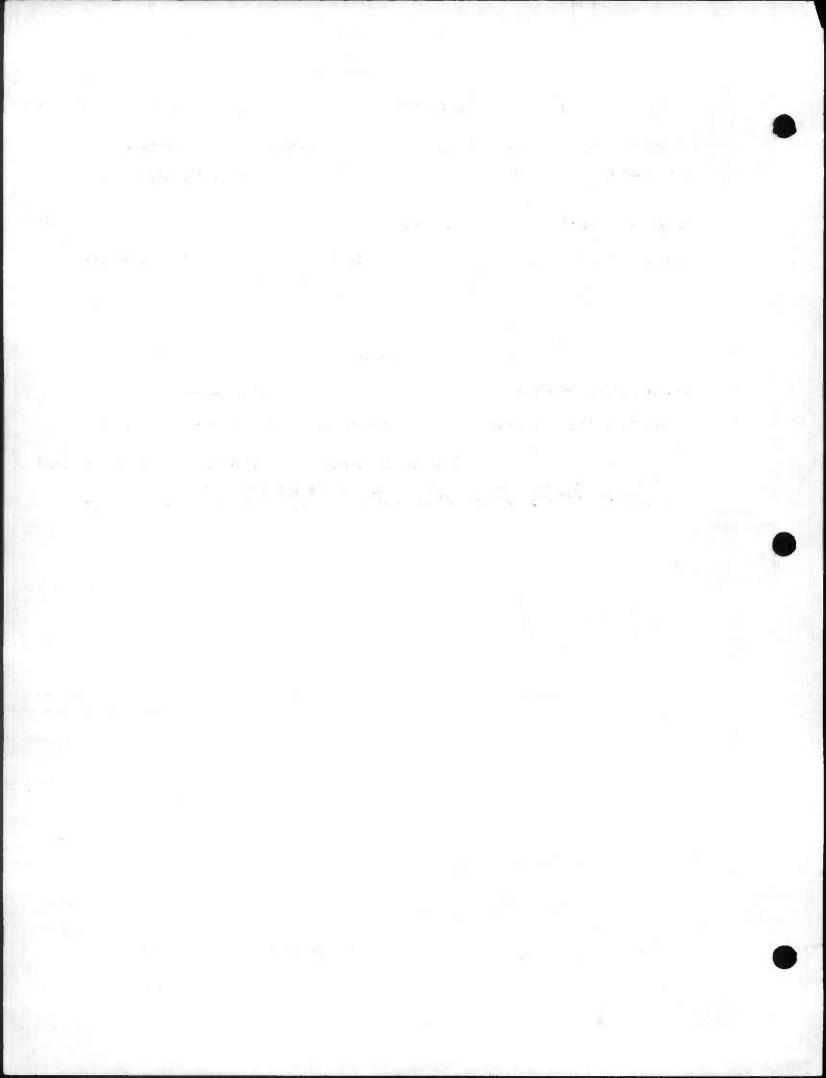


		State of		epartment of F Certificate of			giene 9 Reg. No.	9 3 1 8 4 6	
Physician	1. Decedent's Name (First, Mide	dle, Last)				2. Dete of De Month	nath Dey	3. Time of Death	
Physician /Medical		nson	Speak			August	31, 1	1999 6:15 P.M.	
Examiner	4a Facility Name (If not instituti Frederick 1	on, give street and numb Memorial Hos		100	4b. City, Town, o Freder	or Location of Death 4c. County of Death			
Funeral Director	5. Social Security Number 214–32–2548		Age (In yrs. last birth	day) If Under 1 Year Months Deys	If Under 24 Hi Hours Mi	e To Data of Bir	44	9. Birthplace (State or Foreign County) Mary Land	
	Usual Residence of Decedent					Dec. 3	1, 1,000	zary zara	
Marylan H ahow fied at	Maryland Frede	v erick	10c. City, Town Myersv					10d. Inside City Limits 1 ☐ Yes XXNo	
with the Ma e or 28e-f a be notified	10e. Street and Number 9518 Hat	rmony Road		10f. Zip Code 21773			10g. Citizen of Whet Country?		
72 hours after death with the Maryland natural, or items 23s or 28s-f ahow 25st Examinar ment be notified at sted by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Wes Decede Armed Force 1 Yes 2	9\$? 🖸 No	13. Was Decedent of H	tispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) Specify:		14. Race Blec	e-American Indien, k, White, etc. White	
ad within 72 hours ygjene. her then "neturel", rt, the Medical Ex-	15. Decede (Specify only high Elementary/Secondary (0-12)	16a. Decedent's Usuel Occupation (Give kind of work done during mo life. DO NOT use retired) Sexton			ring most of working		siness/Industry		
E L SO A	17. Father's Name (First, Middle Clarence					ne (First, Middle, Maiden Sumeme)			
d 2 sho th and 7 le m traum	19a. Informant's Name/Relation Mrs. Linda M. Spe			Mailing Address (Street 18 Harmony					
Pages 1 an nant of Heal nt: If Itam 2 iry or other	20a. Method of Disposition AD Burial 2 Cremetion 4 Donation 5 Other (. cemetery.	Disposition (Name of crematory or other place Cemetery,	Sept. 3	Dete 1999		city or Town, State	
permit. Page Department of Important: If any Injury of page.	21. Signature of Funeral Service 23a. Part 1. Enter the disease, shock, or heart failure. Lis	0 10 .	MO0255	22. Name end Addre Keeney ar	J Doof	rd P.A.	Funeral	Home	
eath certificate be associated strength of the second of t	tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as a co	mucsc insequence of): (lsc hercs piden	Lemic is		Days years years	
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£ 53	1 Yes 25 No 27. Manner of Death 1 Anatural 5 Pend 2 Accident invest	28a. Date of I	1	tome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
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To the Hospital within 24 hours of the Funeral completely filled	29a. Certifier (Check only one)	Physician: To the be d Examiner: On the basis and manner	s of examinetion end/	death occurred at the tir or investigation, in my o	ne, date and pla pinion, death oc	ce, end due to the curred at the time,	cause(s) and me date end place, a	nner as stated. and due to the cause(s)	
within To th comp	29b. Signature and title of certific	durer		29c. Licens	e number		29d. Date signed	(Month, Dey, Year)	
	30. Name and address of person	who completed cause of	A 444 - 100-	ype, Print)	threw	DRIVE	FRENI	Skelt Mn	
State Registrar	31. Date filed (Month, Day, Year	32. Regi	strar's Signeture	· B.	6-1	7	, , , , ,	· · · · · · · · · · · · · · · · · · ·	



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end 2 seeth er n 27 is		Glenn W. Smith / h	usband	700) Long	Corn	er Road,			21771			
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/Medical Examiner		Immediate Ceuse (Final disease or condition resulting In death) e.	Septer St Due to Acure Mu	bull	nsequence	of).					12 hours	1	
pet les	Examiner	b .	Acure mu	your	nav nsequence	Frefs	nta				12 hou	v	
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5 0 0	n/Medical	-	resulting in deeth) Lest	U Dua to	gerase co	nsequance o	or):						
- 9 ep	Physician/N	Pert II. Other significant conditions contr	buting to death but not	resulting In t	he underlyin	ig cause giv	en in Pert I.	23b. Dld	tobacco use co	ontribute to	the cause of	f death?	
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Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	27. Manner of Death ↑ Neturel 5 □ Pending 2 □ Accident Investigation	28e. Dele of Injury (Month, Day Year) 28b. Tim Inju				Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred						
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To th withir To th comp	Me	29b. Signature and titla of certifier				29c. Licenso			29d. Dete signe				
		30. Name and eddress of person who com	pleted cause of death //	tem 22a) /T	una Print)	P-3	34868		7610 12	,159	4		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Neme (First Middle Last) 2. Dete of Death 3. Time of Death Dev Month **Physician** Bertha Wilkins Simms Sept. 1999 5:30am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) **Examiner** Rockville Montgomery Hospice Casey House Montgomery If Under 24 Hrs. If Under 1 Year Birthplace (Stete or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) 1 M 2 K Months Deys Hours Min Yrs. 578-22-2938 3, 1924 Washington D.C. May Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Directo Maryland Montgomery Damascus 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 25835 Woodfield Road Funerai 20872 United States 12. Wes Decedent Ever in U,S Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk Washington Gas Light 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Unknown Wilkins Elizabeth Kracke 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) George A. Simms/ Husband 25835 Woodfield Road, Damascus, Maryland 20872 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donetion 5 □ Other (Specify) 9/4/99 Brentwood, Maryland Ft. Lincoln Cemetery 21. Signeture of Funeral Servica Licenses 22. Name and Address of Fecility Olin L. Molesworth P. A. Funeral Home 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one leuse on each line. 20872 Approximete intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in death) e Metastatic Adenocarcinoma of Unknown Primary 2 Years Due to (or as e consequenca of): Physician/Medicai Examiner (Prob. Breast CA) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequença of) Due to (or es e consequence of) resulting in deeth) Lest 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Hepatic Failure due to metastatic disease ģ 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homleide edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end/manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Dete signed (Month, Dey, Year) D37620 Sept. 1, 1999 dd dause of death (Item 23a) (Type, Print) Mark Godec, MD. 4421 Sleaford Road, Annandale, Virginia 22003

32. Registrer's Signeture

1999

State Registrar

Funeral

Director

28a-f show

7 is marked other than "naturel", or frema 23s or 28s-f show traumatic event, the Madical Examiner must be notified as

permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiane. Important: If item 27 is marked other than "naturel", or itema 23e any Injury or other traumatic event, tra Medical Experimental PROB.

Physician /Medical

Examiner

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The law requires that the death certificate be executed

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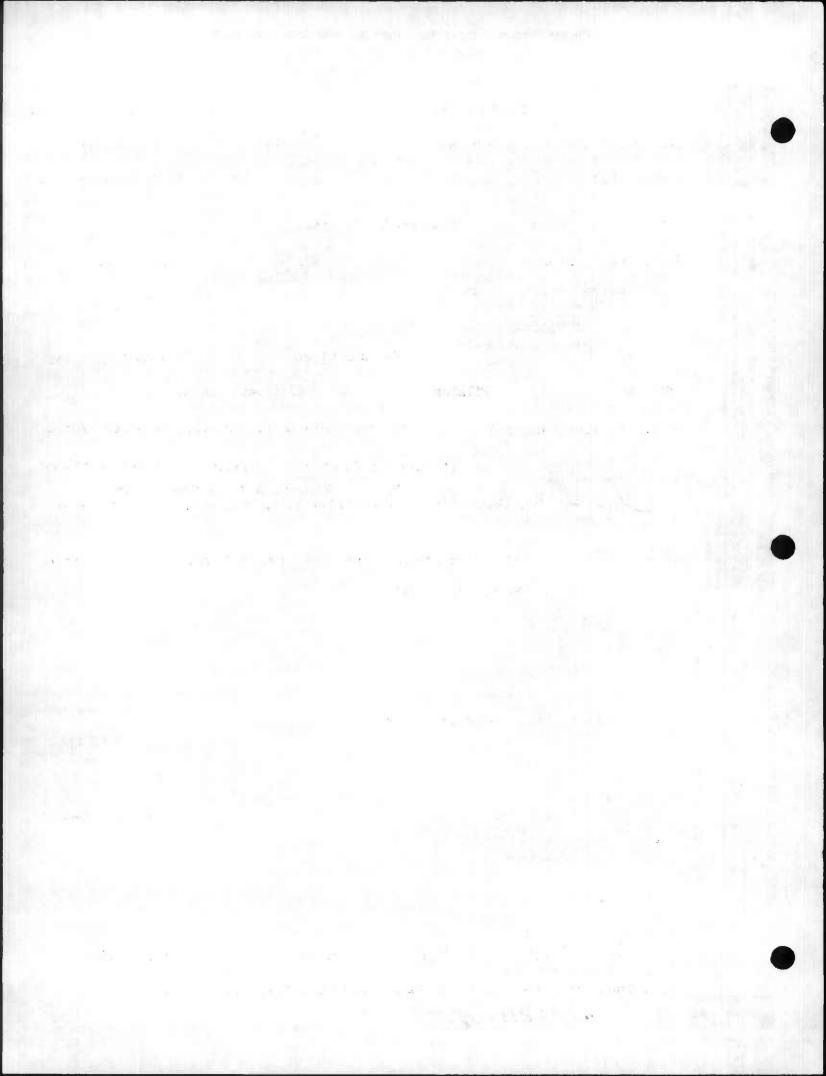
Physician:

Hospital or Attanding

altimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** September 2, 1999 Kenneth Richard Smith 4:47 p.m. /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Yea 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Hours Director 219-44-4362 Oct. 7, 1946 | Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location ahow 10d. Inside City Limits r then "natural", or hems 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 North Market Street United States
lo- 14. Raca - American Indian,
Black, White, etc. 21702 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiane. Important: if item 27 is marked other than "natural". or House injury or other treumatic avaired. 1 Yes 2 No
If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: p 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) North American Elementary/Secondary (0-12) College (1-4or 5+) 12 Fork Lift Driver Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Smith Mary Catherine Stine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce A. Smith / wife 511 N. Market St., Frederick, Maryland 21702 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 9/7/99 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 23a. Part / Enter the disease on complications that caused the dealt. Do not enter the mode of dying, such as cardiac or respiretory errest, about failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Esophageal Cancer Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobacco usa contribute to the cause of death? Pert II. Other algorithmat conditions contributing to death but not resulting in the underlying cause given in Part I. P.0 3 Probably 4 Unknown 1 Yes 2 No Records, by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred edical Certification: 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D44164 9-6-1909 HEGAZI, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801 TOLLHOUSE D-3, FREDERICK MD 21701 31. Date filed (Month, Day, Year,

DHMH 16 Rev 6/95

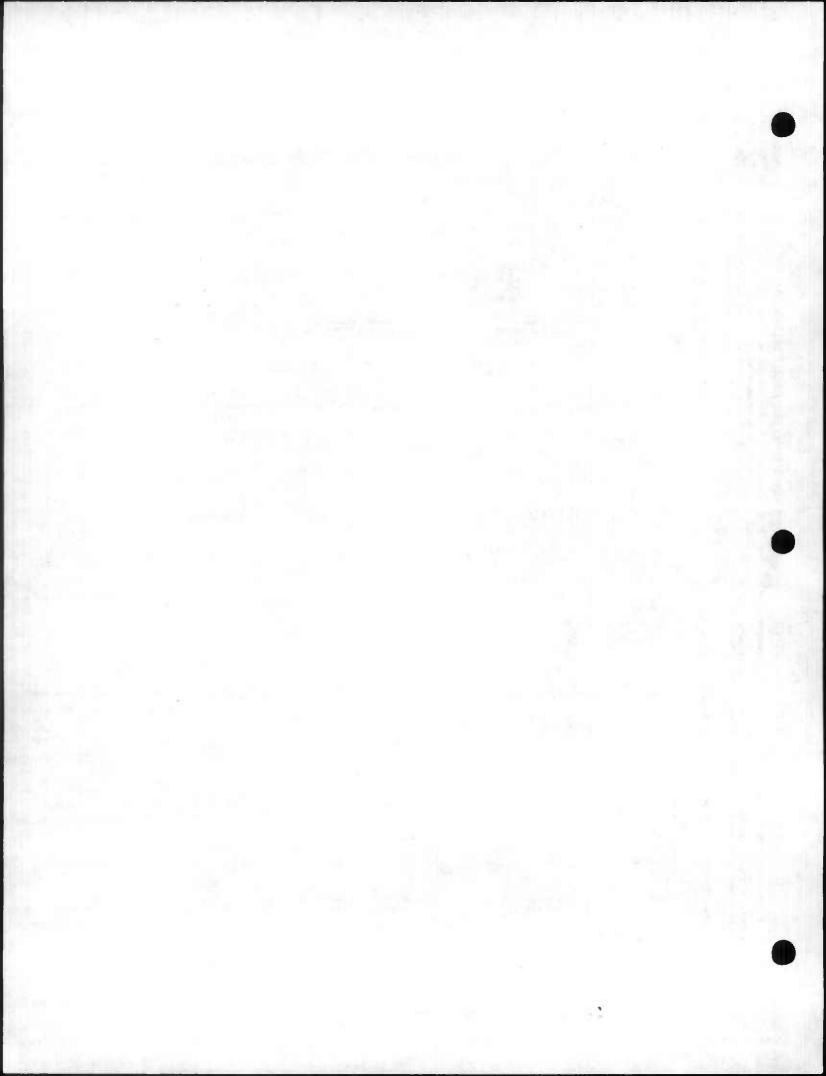
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32. Registrate Signature

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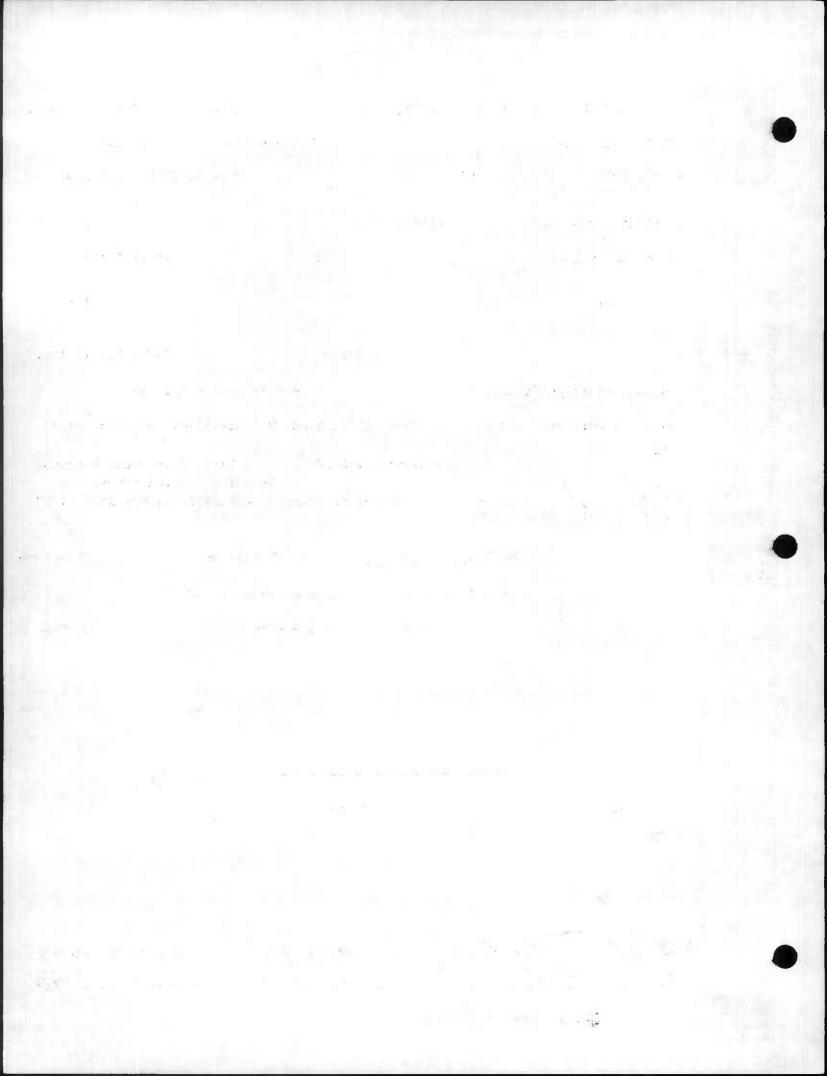
State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** September 5, 1999 JOSEPH LLEWELLYN STALEY, JR. 6:40 P.M. /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** 9544 Dublin Road Walkersville Frederick If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1X M 2□ F Yrs 219-68-9624 Director June 9, 1956 Maryland Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Frederick Walkersville 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code permit. Pages 1 end 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Mod cal Examiner must be no 9544 Dublin Road 21793 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify. White þ 3 Widowed 4 Divorced Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) BioWhittaker, Inc. Laborer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Joseph Llewellyn Staley, Sr. Bettie Regina Main 19e. tnforment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9544 Dublin Road Walkersville, Maryland 21793 Susan R. Hoffman, sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition XXBuriel 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 9/9/99 Frederick, Maryland Resthaven Mem Gardens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 40 Fulton Avenue Walkersville, Maryland 21793 40 Fulton Avenue Walkersvil. Approximete Intervel Between Onset end Deeth **Physician** /Medical tmmediete Ceuse (Finel 12-5pi-ot-00 diseese or condition resulting in deeth) 2 4= =5 Examiner Due to (or es e consequence of): Examiner 7 4 510 C physician and the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): as USB signed by the a 23b. Did tobacco use contribute to the cause of death? Pert It. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed certificata has t lirector, page 2 s 1 Yes 2 No 1 Yes 2 No al or Attending Physician: The safer death.

In Director: After this certificated in by the funeral director, positions. Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Yes 2 No Investigation 2 Accident in 24 hours
the Funeral Director
Tilled in by the 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury - At home, ferm, street, fectory, offica building, etc. (Specify) Hospital 24 hours a 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner stated. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b Signature and title of certifier 1146 DC 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🔾 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 3, 1999 Rosanne (NMN) Sammons September 6:00 PM /Medical 4b. City. Town, or Location of Daath 4e Facility Nema (If not institution, giva street and number) 4c. County of Death Examiner 5800 Genesis Lane Frederick Frederick If Undar 1 Yaer 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yaar) Birthplaca (Steta or Foraign Country) **Funeral** Days Hours Months 219-14-9605 1□M 2□F 78 Yrs. Director Oct. 19, 1920 Maryland Usuel Residence of Dacedant the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f shorter than Medical Examiner must be notified at Maryland Frederick 1 Yas 2 No Frederick Director 10e. Street and Number 5800 Genesis Lane 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after deeth with nest of Health and Mental Hygiene. Anti If item 27 is marked other than "natural", or items 23a or with yor other traumatte event, the Medical Express. 21703 U.S.A. Funerai 12. Wes Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☑No If Yas, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Race - American Indien, Biack, Whita, atc. 11. Marital Stetus 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White altimore, Maryland 21215-0020 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Nama (First, Middla, Meidan Surname) 17. Fathar's Nama (First, Middla, Last) Be Austin Haffner Jane Birely 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Jamie Chase/Daughter 1502 Bedford Road, Wilmington, Deleware 19803 20c. Location - City or Town, Stata 20h. Placa of Disposition (Nama of 20a. Mathod of Disposition Mt. Olivet Cemetery 1X Burlel 2 ☐ Cremetion 3 ☐ Removal from Stata 1999 Frederick, Md. Sept. 10, permit. Pege Department of Important: If any Injury or pace. 4 ☐ Donation 5 ☐ Othar (Specify) eture of Funerel Service Licensea 22. Nama and Addrass of Facility Keeney & Basford Funeral Home 106 East Church Street, Frederick, Md. 21701 M00021 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximeta intarvel Between Onsat and Death **Physician** /Medical Immediate Causa (Finel INFarction Minutes disaasa or condition rasulting in daath) Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be executed physician end is the buriel-trans Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Diseasa or Injury that initiated avants resulting in daath) Lest Due to (or as a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): for use as signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown tension by 24b. Were eutopsy findings availabla prior to complation of cause of death? should 24e. Wes en autopsy Completed il director, pege 2 s 1 ☐ Yas 2 ☑ No 1 TYAS 2 No. To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifica completely filled in by the funeral director; E Be 25. Was casa rafarred to medical 26. Placa of Death (Check only one) Assisted Othar: 4 Nursing Homa 5 Residenca 6 Othar (Specify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA Fackly 28c. Injury at Work? 28d. Describe how Injury occurred 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida Location (Streat end Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicide Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signature and titla of certifier 29c. Licansa number lole MO MO51610

Frederick MD

State Registrar 30. Nama and address of person who completed cause of death (Itam 23e) (Type, Print)

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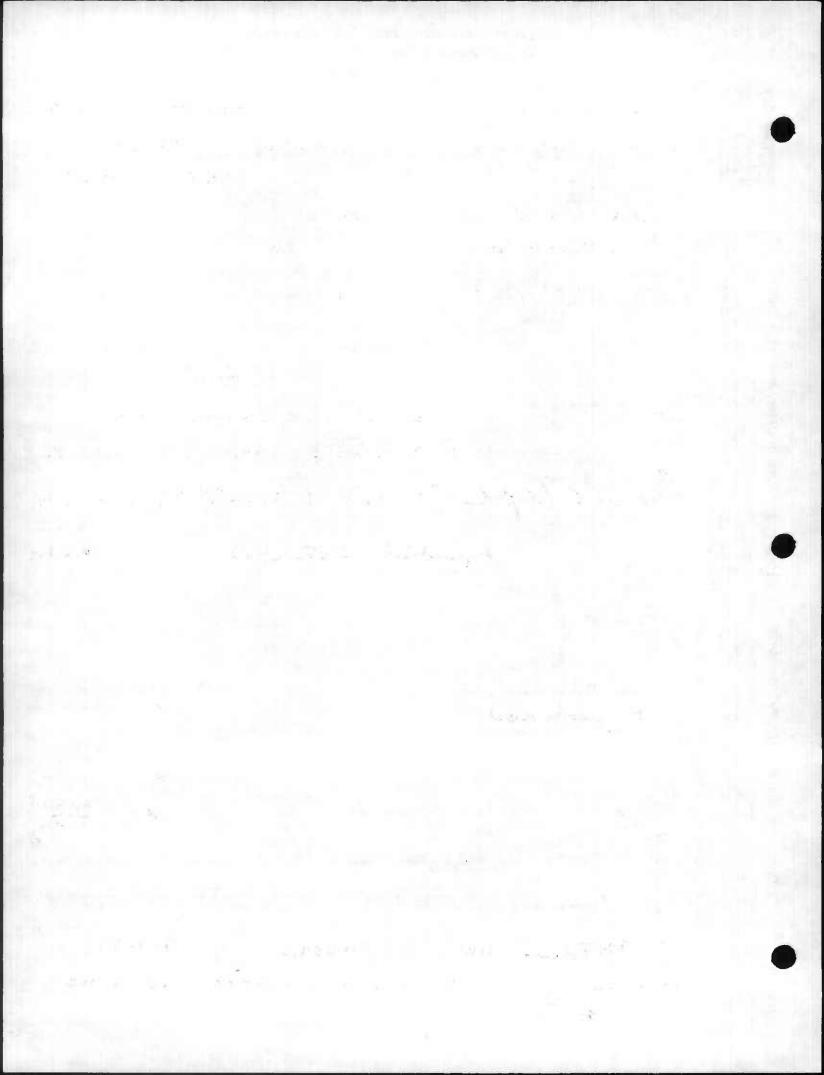
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32. Registrar's Signatura

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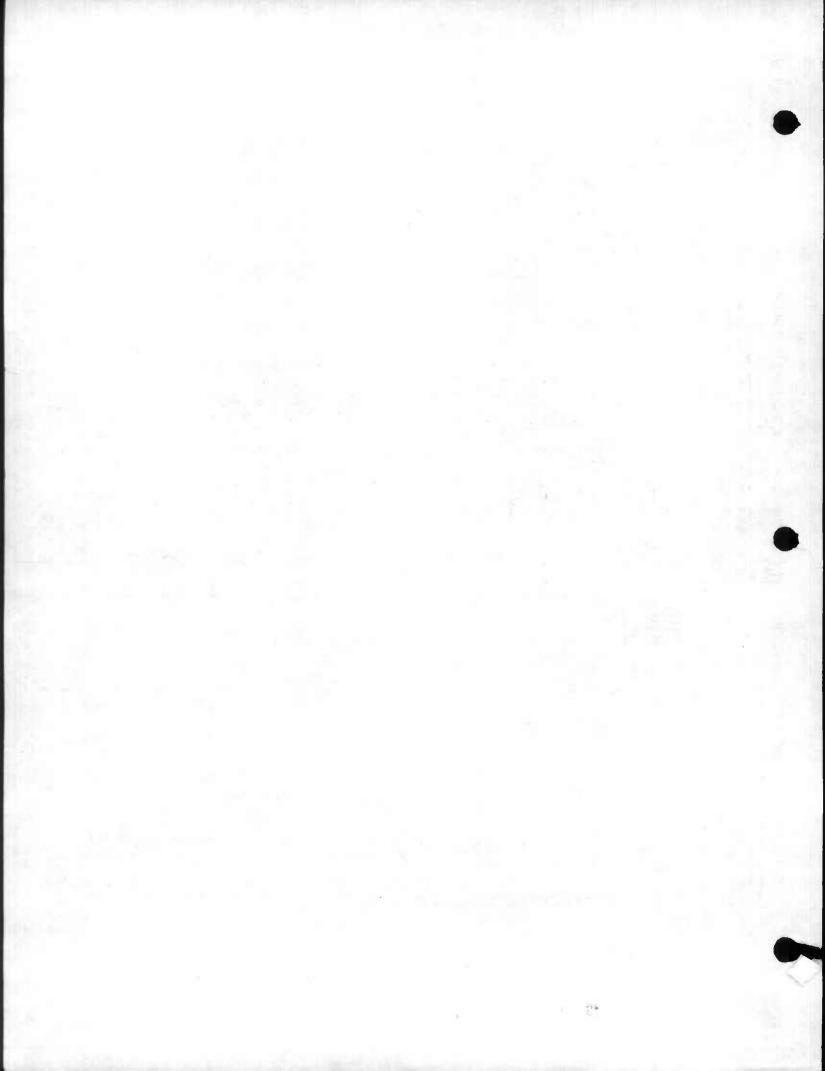


State of Ma

ryland / Department of Health and Menta	Il Hygiene	01000
Certificate of Death	Reg. No.	31852

		1. Decedent's Name (First, Middle, La						2. Dete of Death Month Day Year 3. Time of Dea				
ā	Physician /Medical	Larry Way	yne Staub, Jr.					Septem	ber 09,		9 11:06 P.I	
	Examiner	4a Facility Name (If not institution, git	re street end number)			4b. City,	Town, or L	ocation of Dea	th 4c. County	of Deeth	h	
0.81	Frederick Memori 5. Social Security Number 6.		lant histhelass	If Under 1		deric	-					
ı	Funeral Director		Sex 7. Age (In yrs. 11 1	Yrs.		ays Hour		8. Date of B (Month, D Aug. 7	, 1974	Vir	hplace (Stete or Foreig untry) ginia	
	9	Usuel Residence of Decedent 10a. State 10b. County	100 C	ty, Town or Lo	ention						10d Inside City Limit	
	the Maryland 28a-1 show stiffled at ector	Maryland Frederic		rederio							10d. inside City Limit	
	h with the Me 23e or 28e-f e at be notified al Director	10e. Street and Number 10009 Putman	Road		10f. Zip Co				U.S.A.		untry?	
20	72 hours after death with the Maryle natural, or Items 23a or 28a-f sho dical Examiner must be notified at eted by Funeral Director	11. Meritel Stetus 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ŽQŽNo If Yes, Give	- Br	Vas Deceden f Yes, specify I□ Yes 2☐	Cuban, Mexi	can, Puerto	ecify Yes or N Rican, etc.)	Blac	ce - Americk, White		
21215-0020	thurs thurs	15. Decedent's E	Year or Detes:	16a Decer	lent's Usual C	ocupation			16b. Kind of Br	usiness/l	Industry	
15	in 72	(Specify only highest gr	ede completed)	(Give	kind of work of	lone during n etired)	nost of work	ing	100. 11110 01 01	20111000		
212	led within 72 ho tyglens. her than "naturn it, the Medical.] Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Pair	nter				Paintir	ng Co	ontractor	
Maryland	Sabe es	17. Father's Name (First, Middle, Last Larry Wa	yne Staub, Sr				ther's Nem		e, Meiden Sumen Nipp			
Mary	d 2 should th and Men 7 is marks treumatic	19a. Informent's Neme/Relationship Mrs. Frances A. M							ber. City or Town, rederick			
e,	Files Mem 3 Offher	20a Method of Disposition	20b. F	Place of Dispo	ot Disposition (Name of lever, cremetory or other place) Colivet Cemetery, Sept. 14, 1999				ate 20c. Location - City or Town, S			
timore, t. Pages 1 at timent of Nea tjury or othe	nit. Pages artment o ortant: If I Injury or	A Burial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Speci	y) Mo	unt Oliv					9 Frederick, Maryl			
Departing on the parting of the parting on the parting of the parting on the part		21. Signature of Funeral Service Lice	Fral M002		Reeney and Basford P.A 106 East Church St., F.							
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plicetions that caused the deet							ICI .	Approximate Interval Between	
V	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	b	or as e conseq	uence of):	of the	Let	t Ches	t and L	eg		
o,	e exec ian an urial-tri	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.										
ox 68760	th certificate be executed tending physician and x use as the burial-transit an/Medical Examiner	that initiated events resulting in death) Last	Due to (o	or es a conseq	uence of):							
80			**							1		
P.O.	hat the dea of by the att detached for Physici	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying caus	se given in Pe	ort I.				to the cause of death robably 4 Unkno	
Division of Vital Records,	The law requires that the death cate has been signed by the atter page 2 should be detached for Completed by Physicia							24a. Wa	s an autopsy formed?	1	Were autopsy findings available prior to completion of cause of death?	
E	The law ate has page 2							16	Ves 2□No		1 Nes 2□ No	
a	stelan: The certificate irector, pag 5 Be Co	25. Wes case reterred to medical	26. Place of Death					th (Check only				
>	hysici his ce al direc	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 反	ER/Outpatien	t 3 DOA	Other: 4	Nursing He	ome 5□Re	sidence 8 Oth	ner (Spe	city)	
ouo	Attending Physician: ordesth. ector: After this certific by the funeral director, iffication: To Be (27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28b. Time of linjury at Work?			28d. Describe	28d. Describe how injury occurred police			
DIVISI	ital or Attending Physics attendesh. al Director: After this led in by the funeral of Certification: To	3 Suicide 6 Could not to determined		ome, term, str	eet, tectory, o	ffice		281. Location City or T	(Street and Numl own, State) Mu	ber or Ru	rel Poute Number.	
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	vithin forth sompl	29b. Signature and title of certifier	1 04		29c. L	icense numb	er		29d. Dete signe	d (Monti	h, Dey, Year)	
		Alexan	Check			O.C.M.	E.		Septembe	r 10), 1999	
		Dennes of parson who	completed cause of death (Item			Stree	et, Ba	altimor	e, Maryl	and	21201	
	State Registrar	31. Date tiled (Month, Dey, Year)	3 1999 A Pagistrary Signs	ature	6.	Spar	Ka 1					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 6, 1999 Physician Robert Marshal Stroud Sr. 9:30 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 8. Dete of Birth (Month, Dey, Year)
Aug. 23, 1927 Ohio 7. Age (In yrs. last birthday) **Funeral** Days 1以M 2□ F Yrs. 280-22-6766 Director **Usual Residence of Decedent** 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or frame 23a or 28a-f ahow 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21701 839 Dunbrooke Court Funaral deeth 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filled within 72 hours effer to Department of Heelih and Mental thyglene. Important: If flem 27 le marked other than "natural", or free eny injury or other treumatic event, the Medical Examinat Pace. 1 X Yes 2 No If Yes, Give Year or Detes: 1945-64 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yea 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Systems Analyst Computer 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 2 Agnes Marie Brislen Francis Marion Stroud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 839 Dunbrooke Court, Frederick, MD 21701 Barbara Ann Stoud 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 N Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 9/14/99 Arlington, Virginia 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licenses 21701 MO0999 106 East Church Street, Frederick, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical PNEUMONIA WEEK Examiner Due to (or es e consequence of): Examiner ART PIOLYMOR or Attending Physician: The law requires that the deeth certificate be executed physicien end the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760. Physician/Medical Due to (or es e consequence of): been signed by the e should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. à Complated 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Cartification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 SNatural deeth. 1 Yea 2 No To the Hospital or Attendit within 24 hours effer deeth. To the Funeral Director: Al completely filled in by the fu investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mil Warard SEPTEMBER 6, 1999 D47611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

NEIL WARAVORICAN

31. Date filed (Month, Day, Year)

AVE.

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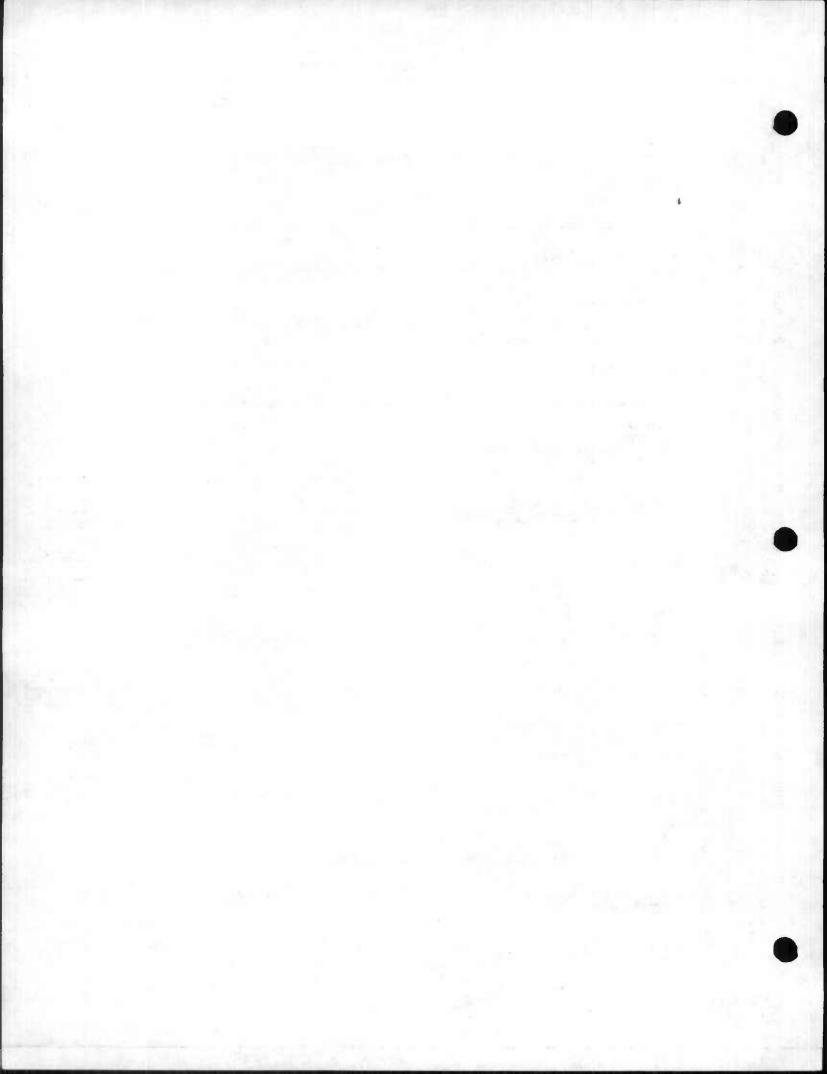
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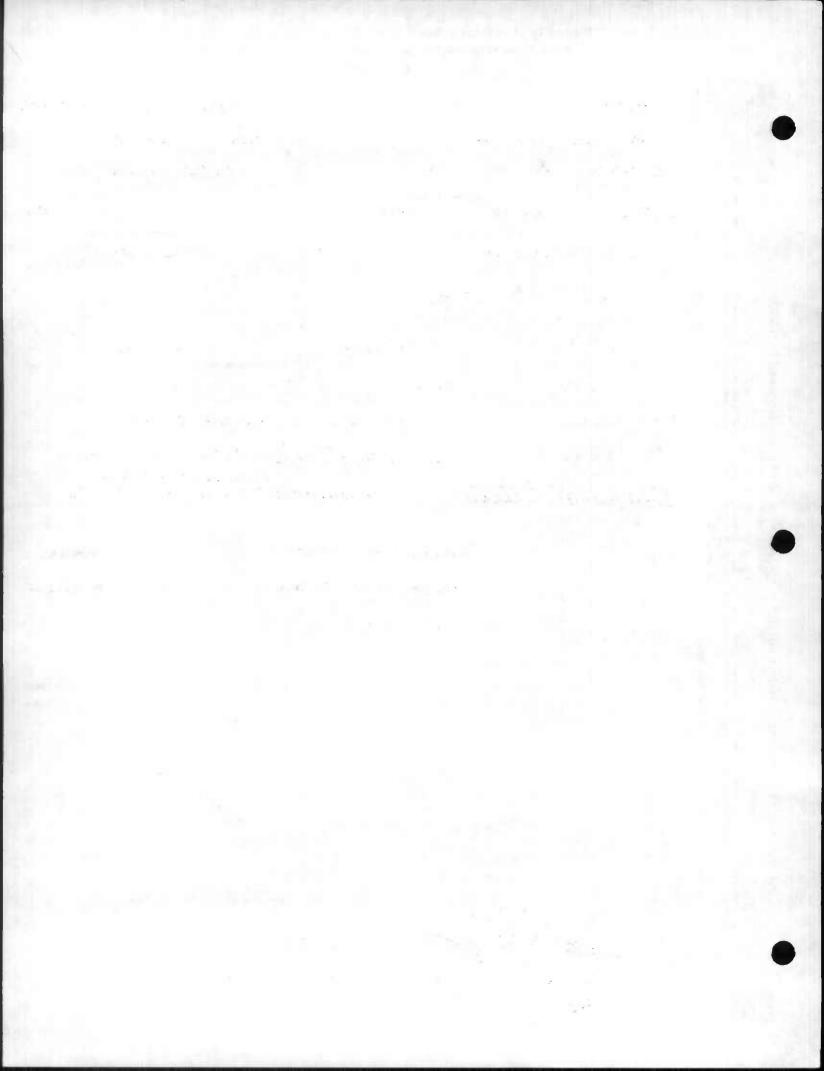
32. Registra s Signeture

MD

SEP 0 8 1999 >



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 14, Walter Sikora Sept. 1999 5:40 P.M. /Medical 4c. County of Death 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner 6945 Golden Valley Court Frederick Frederick if Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours M 2DF Yrs. 68 Director 135-24-0636 Feb. 16,1931 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 20 No Frederick Frederick Maryland Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number with 6934 Golden Valley Ct. United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No 1 Never Married 2 Married If Yes, Give Viet Year or Dates: Viet 1 ☐ Yes 2 1 No altimore, Maryland 21215-0020 Specify: Specify: by 3 ☐ Widowed 4 💆 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Military U.S. Air Force permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Michael Sikora Drobnika Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Sikora / son 24428 Cutsail Dr./ Damascus, MD 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) land 1 Buriai 2 Cremation 3 Removel from State Garrison Forest, Veteran 9-21-99 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of Fecility Stauffer Funeral Home 21 Signature of Funeral Service Licenses 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part 1. En fir the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. aymony elecson Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CARDED PULMONATOY ARREST. MONDIEL disease or condition resulting in death) **Examiner** Due to (or as a consequence ot): Examiner CORDNARY ARTERY DOSGASE Molle-you physician and s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): certificate be exec P.O. Box 68760. Hypertenanon . edicai Due to (or es e consequence of): 88 Physician/M esn 23b. Did tobacco use contribute to the cause of death? ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 Yes 2 No signed t Division of Vital Records. þ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of death? page 2 s Pas 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manger of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homlcide Hospital 24 hours edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and properties of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fits D50207. 9/15/99 ot death (Item 23a) (Type, Print) 30. Name and address of person who complete Frederic WB 21703 SAMUEL ENG, Solares Of. 610 31. Date filed (Month, Day 1997) 1999 Registra State



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 21, 1999 **Physician** William Frederick Steinebrunner 9:15pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9576 Woodland Drive Woodsboro Frederick If Under 24 Hrs. 8. Date of Birth Hours Min. Aug. 1928 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days Months 213-38-9617 15 M 20 F Germany Director Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits the Marylan 28a-f show Woodsboro Maryland Frederick 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8 must be 9576 Woodland Drive 21798 U.S.A. Norra 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, i fled within 72 hours after d i Hygiane. other than "natural", or item Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pattern Maker Pattern Making permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien important: if them 27 is marked other that any injury or other traumetts. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Steinebrunner Berta Ruemmele 19e Informant's Neme/Relationship (Type, Print) Hella M. Steinebrunner/Wife 19b. Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Code) 21798 9576 Woodland Drive, Woodsboro, Maryland 21798 20b. Place of Disposition (Name of Mtcemetely crematory or other place) Sept. 25, 1999 Frederick, Md. 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Keeney & Basford Funeral Home M00021 106 East Church Street, Frederick, Md. 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a Metastatic Non-Small Cell Lung Cancer 1 year Examiner Due to (or as a consequence of): Examiner Cardiomyopathy 6 months The law requires that the death certificate be executed physicien end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as a consequenca of) USB P.0. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 3 Probably 4 Unknown 1⊠ Yes 2□ No Division of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of deeth? Completed 24a. Was an autopsy peed pege 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🗖 Residence 6 □Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Tes 2 No within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fr 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 Homicide ro the Hospital or within 24 hour 1X Certifying Physician: To the best dumy knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated.
2 Medicat Examiner: On the basis of desimilation and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) D36649 September 22, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rav 6/95

State

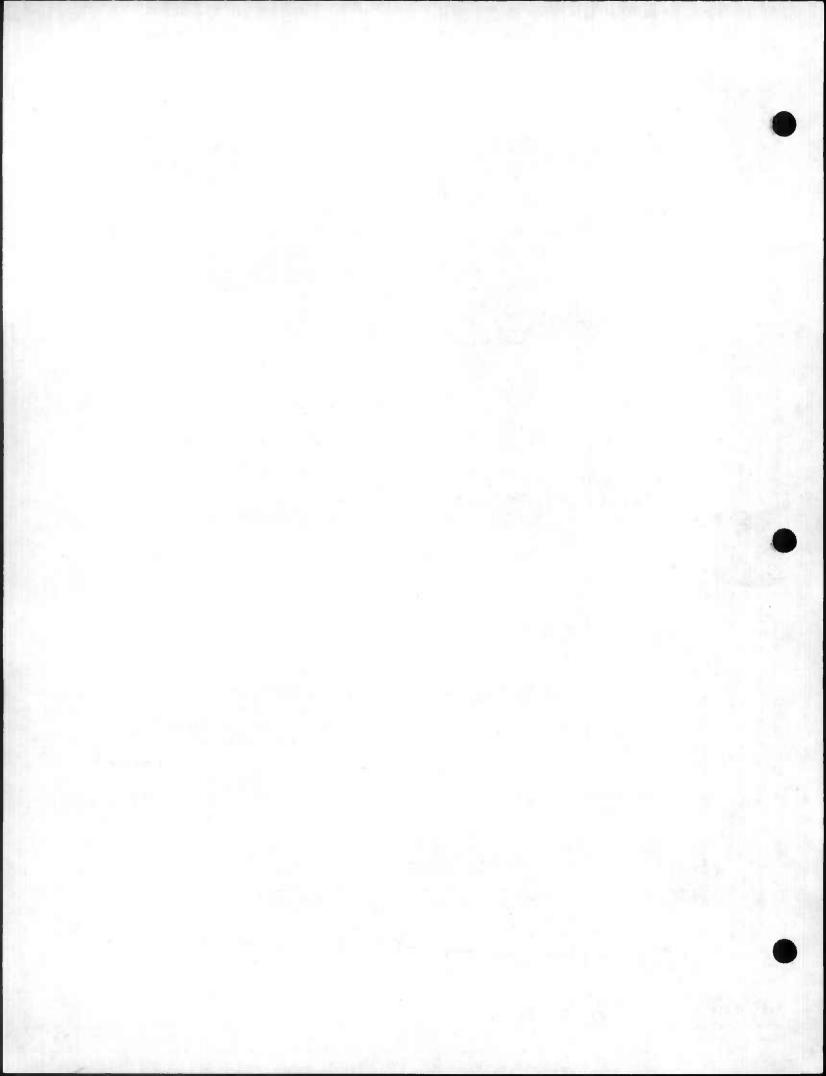
Registrar

31. Date filed (Month, Day, Year)

SEP 2 3 1999

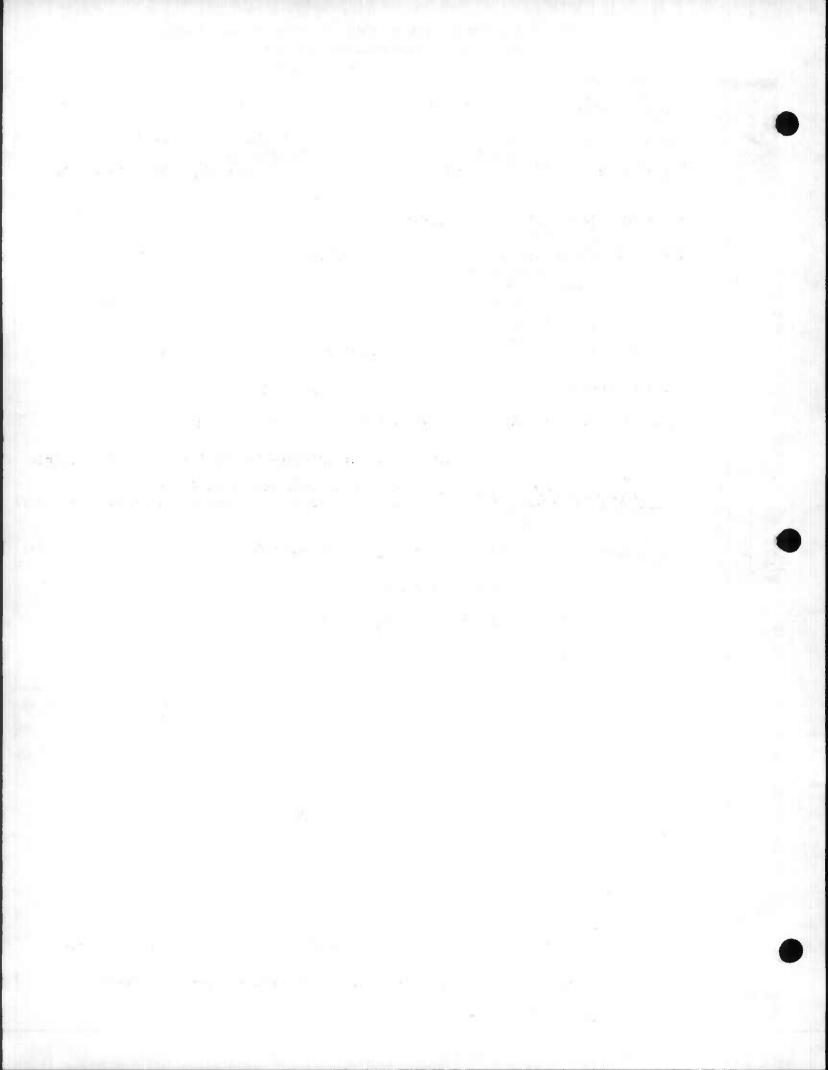
32. Registra s Signature

Edward P. Riuli, M.D., 180 Thomas Johnson Dr, Suite 202, Frederick, Maryland 21702



State of Maryland / Department of Health and Mental Hygiene

					Certificate of Death	,	Reg. No.	0	0105-	
	Dharaisi		Decedent's Neme (First, Middle, Last)			2. Date of Dee	eth Day	Yeer	d. Time of Quath)	
	Physici /Media		Virginia Mae Soude	er			per 23,	1999	2:34 PM	
	Examir		4e. Fecility Name (If not institution, give street end number)		4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth		
1			Citizens Nursing Home		Frederic	k	Fred	erick	2	
	Funeral Director		5. Social Security Number 6. Sex 1		holey If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, De) May 13	v, Year)		ace (Stete or Foreign ry) 165566	
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City	/. Towr	or Location			10	d. Inside City Limits	
	ath with the Marylan 23a or 28a-f show	5							1⊠Yes 2□No	
		Director	Maryland Frederick Fr	ede	rick 10f. Zip Code		10g. Citizen of V	That Countr	2	
	With a	ā			·					
	Z1Z15-UUZU within 72 hours after decides. iene. r then "natural", or items	era	412-B West South Street 11. Marital Status 12. Was Decedent Ever in U.	9	21701	oify Vec or No	United	State - Americe		
020		by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates:	J.	Nas Decedent of Hispanic Orlgin? (Spilf Yes, specify Cuben, Mexicen, Puerto □ Yes 2 ☑ No Specify:	Rican, etc.)	Blac Specify			
2-0		ted	15. Decedent's Education (Specify only highest grade completed)	16e.	Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired)		16b. Kind of Bu	siness/Indu	ıstry	
2121		Completed	Elementary/Secondary (0-12) College (1-4or 5+)	iffe. DO NOT use retired) Homemaker	ng	Own Home				
p	be filed htal Hygi d other event, I	BeC	17. Father's Neme (First, Middle, Last)		18. Mother's Name	(First, Middle,	Maiden Surnem	e)	14	
Maryland	arylan should be ind Mental marked of umatic eve	ToB	Willard Honeycutt		Nola Hil	1				
any	d 2 should th and Mer 7 Is marks traumatic		19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street end Number or Run		r, City or Town,	Stete, Zip (2ode)	
	1 and 2 Health a em 27 la		Philip B. Souder / Husband	41	2-B West South Stree	t, Fred	erick. 1	Md 2	1701	
Baltimore,	of Heal		20a. Method of Disposition 20b. Pl	ace of	Disposition (Name of y, cremetory or other place)	Dete	20c. Location -			
E			I Dunal 2 Micremetion 3 Removaliton State		clitan Crematorium I	nc. 9/25	Alexand	dria	Virginia	
a E	- 544		21. Signeture of Funeral Service Licensee	/	22. Name and Address of Facility	,	111011011	ar ru,	VIIGINIA	
Ö	Depare Important Irr		Olin L. Molesworth P.A., Funeral Home							
e de la companya de l	Physician		23a. Pert1. Enter the disease, or complication. Thet caused the death shock, or heart fellure. List only one cause on each line.	. Do n	26401 Ridge Road, not enter the mode of dying, such es cerdiac	Damascu or respiratory er	s, Maryl	Land	20872-0113 Approximete Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	-	OIAL INFARCTI	ON			Minutes	
	₽ #	ner	HYPERT	Years						
	acute Ind trens	Examiner	V.		consequence of):				Years.	
68760,	icate be executed physician and s the burial-trensit	edical Ex								
Box 6	eath certific attending p I for use as	95	d							
o.	it the dea by the at teched fo	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.						the cause of death?	
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of Vital Records,	aw requires been s	Completed t				24a. Wes	an a <i>u</i> topsy med?	aval	re autopsy findings leble prior to spletion of ceuse eath?	
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ita		Be (25. Was case referred to medical		26. Place of Deetl	(Check only o	ne)			
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	ing After fune		27. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Dey Year)	28b. T	ime of 28c. Injury et Work? M 1 Yes 2 No	28d. Describe h	now Injury occurr	ed		
Division	frer frer in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	me, far	rm, street, factory, office	28f. Location (S City or Tox	Street end Numb m, Stete)	er or Rural	Route Number,	
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my know one) 1 Medical Examiner: On the basis of examination and menner stated.	viedge, ion and	death occurred at the time, date and plece, for investigation, in my opinion, death occurr	and due to the ded et the time, d	ceuse(s) end ma date end place, a	nner es sta and due to t	ted. the ceuse(s)	
	To the To the company	Σ	29b. Signeture and title of confiler		29c. License number		29d. Dete signed	(Month, D	ey, Year)	
			Sang of		D43091		Septembe	er 24	. 1999	
		ŀ	30. Name end eddress of person who completed cause of death (Item	23e) (Type, Print)		F		,	
					ouse Avenue, Frederi	ck, Mar	yland 2	21701		
	Sta	te	31. Dete filed (Month, Day, Year) 32. Registrars Signet		. /	.,	,		-	



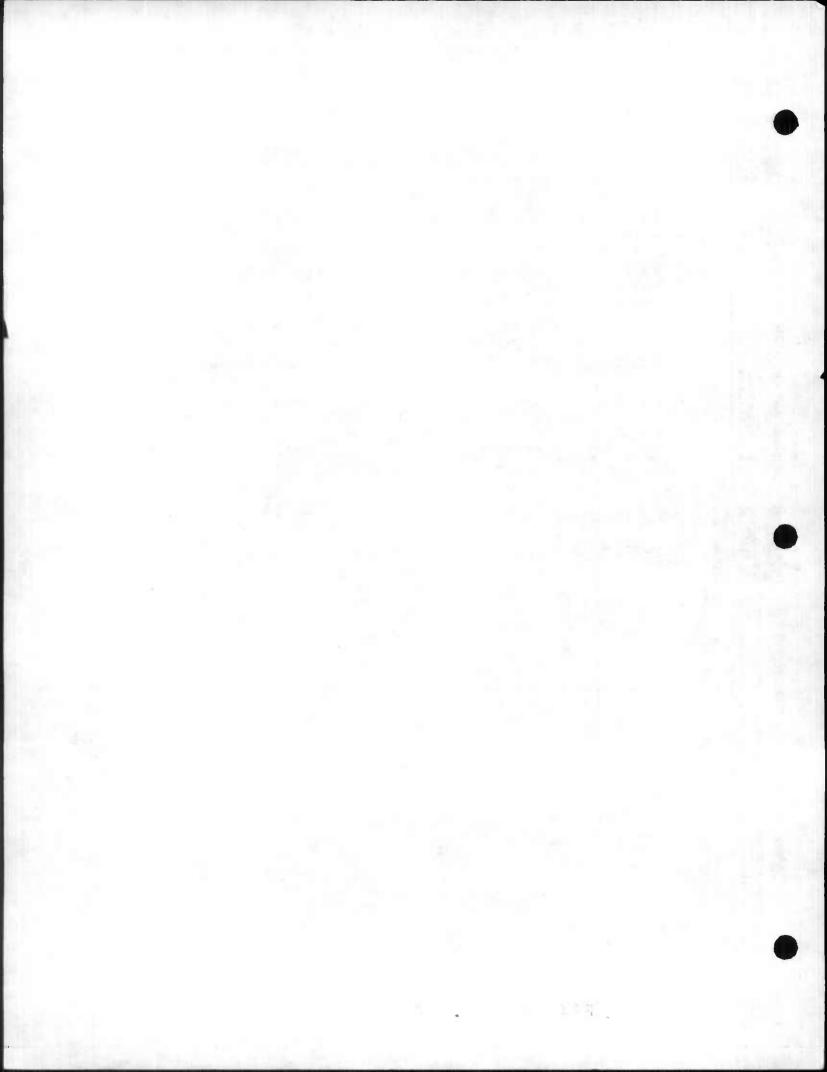
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 15, 1999 Physician GREGORY ALONZA 7:40 AM SNOWDEN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. MARCH 5, 1951 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** 1X M 2 □ F FRED MD 217-58-3062 Director **Usual Residence of Decedent** the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits "netural", or items 23a or 28a-f show X□Yes 2□No MD. FREDERICK FREDERICK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 198 FATRFIELD DRIVE 21702 U.S.A. deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status filed within 72 hours effer. Hyglene. ther then "natural", or its 1 Never Married 2 Merned 1 Yes 2 No Specify: BLACK 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0020 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LAB. CANCER Elementary/Secondary (0-12) College (1-4or 5+) ANIMAL CARE TAKER permit. Pages 1 and 2 should be filed wit.
Department of Heelth and Mantel Hyglene Important: if from 27 is marked other the eny injury or other treumstic event, that page. RESEARCH CENTER 10 TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 ARTHUR H. SNOWDEN, JR. BETTY PATRICIA SNOWDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LORETTA SNOWDEN (WIFE) 198 FAIRFIELD DRIVE FRED. MD. 21701 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cometan, crematory or other place)
RESTHAVEN MEM. GAR. SEPT. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 20,1999 FRED. Md. 21. Signature of Funeral Service License 22. Neme and Address of Facility GARY L. ROLLINS FUNERAL HOME gary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear/feiture. List only or e cause on each line. 21701 Approximate Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical CONGESTIVE HEART FEW WEERS Examiner Examiner ARDIOMYOPATH physicien end the buriei-trensit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. edical Due to (or as a consequence of) Physician/M 997 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by to d be detech 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy lindings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen s certificate has 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No a Hospital or Attending Physicien: 24 hours efter deeth. a Funeral Director: After this certifical stelly filled in by the funeral director, 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Hospital: 1 ∑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 K Natural 1 ☐ Yes 2 ☐ No 2 Accident NA 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie edical (Check only one) To the P within 2 29b. Signature and time of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MI 9.15.99 D18063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABOUL MAJEED TOLL HOUSE AVE FREDERICK MO 21701 801 31. Date filed (Month, Day, Year)

Registrar DHMH 16 Rev 6/95

State

32. Registrer Signature

1999 ▶



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Ray Snouffer Charles September 15,1999 8:10 P.M. /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Min. 1X M 2□ F Yes Director 214-32-9682 64 June 26, 1935 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No Directo Maryland Howard Woodbine 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 8 238 1660 Woodbine Road 21797 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No If Yes, Give 8 altimore, Maryland 21215-0020 1 Yes 2♥ No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Manufacturing Pet Supplies 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be and Mental is marked George B. Snouffer 2 Nellie Ray 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra Joan Snouffer - Wife 1660 Woodbine Road, Woodbine, Maryland 21797 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c Location - City or Town State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State St. Paul's Cemetery 9/18/99 4 ☐ Donetion 5 ☐ Other (Specify) Laytonsville, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Olin L. Molesworth P.A., Funeral Home 23a. Pertl. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

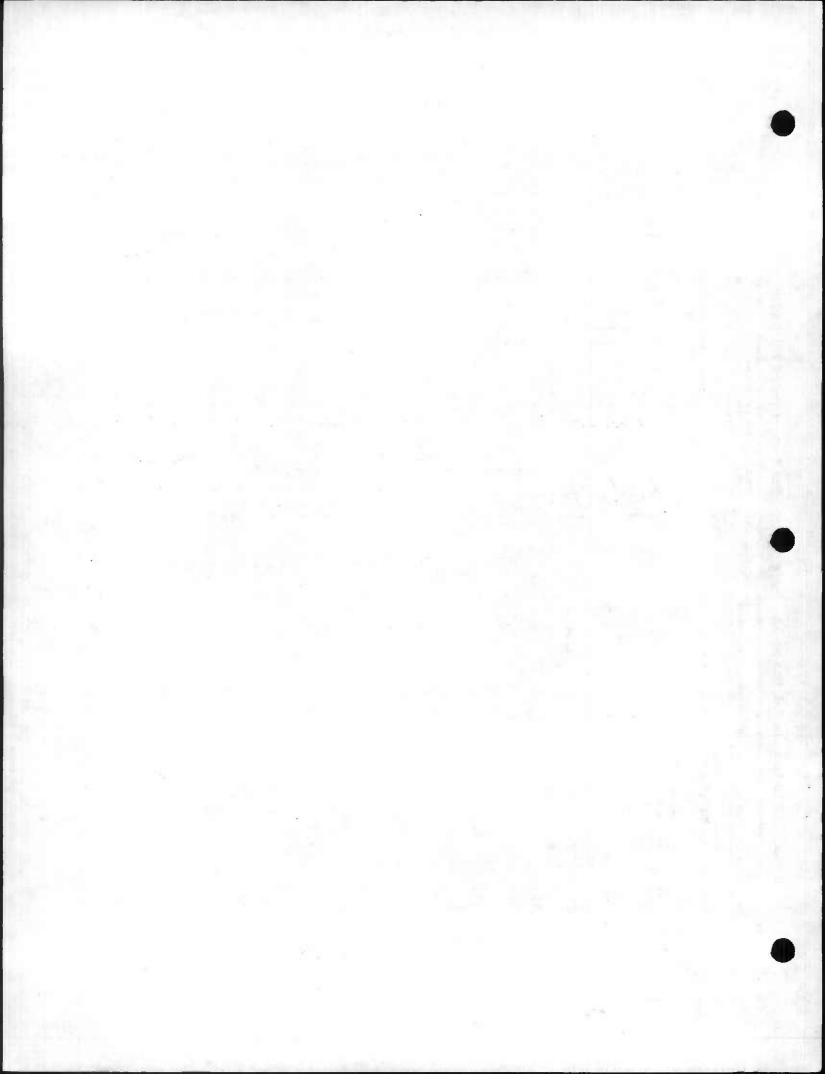
Approximate

Approximate Approximete Intervat Between Onset and Death **Physician** ACUTE TURULAR NECRESIS WITH RENAL PAILURE 3 Mys /Medical Immediate Ceuse (Finet diseese or condition resulting in death) Examiner HYPOTENSICAS Examine Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last HAINY CELL LEUKEMIA 7 YEARS Box 68760 Physician/Medical the Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? INSULIN DEPENDENT D'ABETES 1 Yes 2 No 3 Probably 4 Unknown py Records, NEW ATRIAL FIRRICIATIONS 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy PRIOR STAPHYLOCOCCUS ARREUS 1 ☐ Yes No 1 Yes Division of Vital Attending Physician: Be 25. Wes cese referred to medical examiner? 26. Piaca of Deeth (Check only one) Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Certification: To 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending 1 ☐ Yes 2 ☐ No ...cspital or Atten in 24 hours after death • Funeral Director: A stely filled in by the death. Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.

[In Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier edical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number ress of person who completed cause of deeth (them 23a) (Type, Print) O'CENNOL MD SOI W, SEVENTH ST. FREDERICK MB State Registrar

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		Certificate of Death	Re	g. No.	01000		
DI	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death		
Physician /Medical	Margaret Strine	Tabor		30, 1999			
Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death	4c. County of Do			
	RAVENWOOD LUTHERAN VILLAGE	HAGERS		WASHING	TON		
uneral irector	5. Social Security Number 220–46–7541 6. Sex 1 M 2 TXF 89	rs. last birthday) Yrs. Months Days Hours Mi			Birthplace (State or Fore Country) PA		
	Usual Residence of Decedent		ray aaş	*/*/			
or 28a-f show be notified at Director		City, Town or Location			10d. Inside City Lim		
	MD. Frederick	Middletown			1 ☐ Yes 200		
0 M D	8027 Pete Wiles Rd.	10f. Zip Code 21769	10	Og. Citizen of What U.S.A.	Country?		
d other than "natural", or harms 23s event, the Medical Examiner must Be Completed by Funeral	11. Marital Status 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 3/1 No II Yes, Give Yeer or Detes:	U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1□ Yes 2☒No Specify:	(Specify Yes or No- erto Rican, etc.)	Bleck, W	merican Indian, hite, etc. White		
		16a. Decedent's Usual Occupation (Give kind of work done during most of wife. DO NOT use retired)	vorking 1	16b. Kind of Business/Industry			
A DE	Elementary/Secondary (0-12) College (1-4or 5+)						
vent, it	12 17. Father's Name (First, Middle, Last)	homemaker	Iomo /First Middle M				
ls marked other numatic event, To Be C	Otto E. Strine		Householde				
Nem 27 is marked other traumatic ex To B	R. Michael Tabor (Son)		dress (Street and Number or Rural Route Number, City of te Wiles Rd., Middletown,				
or other	TABOUTAL 2 CONTINUES 3 CHANGE TOTAL STATE T.	o. Pleca of Disposition (Name of cemetery, crematory or other plece) utheran Cemetery		20c. Location - City Iiddletow			
any injur- ans injur- anse.	4 Donation 5 Other (Specify) 21. Signature of Funoral Service Licenses	22. Name end Address of Fecility Donald B. Thomps					
physician and is the buriel-transit defical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	monary Arrest o (or es a consequence of): o (or es a consequenca of): of Alzheimer's Type (or es e consequence of):			INSTANT 2 WEEKS MANY YEA		
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ctor: After y the funer fleation:	27. Manner of Death 1 XNeturat 5 Pending 2 Accident investigation 28a. Dete of thjury (Month, Day Year)	28b. Time of lnjury M 28c. Injury et Work? 1 Yes 2 No	28d. Describe ho	w injury occurred			
of Director: After tied in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - A building, etc. (Spe	t home, ferm, street, fectory, office city)	28f. Location (Str City or Town,	n (Street end Number or Rurel Route Number, Town, State)			
To the Funeral Director Completely filled in b	29a. Certifier (Check only one) 1 Certifying Physician; To the best of my k 2 Medical Examiner: On the basis of examinand menner steted.	nowledge, deeth occurred et the time, date end pla ination and/or investigation, in my opinion, deeth oc	ice, end due to the ca courred et the time, da	use(s) and manner ite end piece, end d	es stated. due to the cause(s)		
ompi	29b. Signeture end title of certifier	29c. License number	29	d. Date signed (Mo	onth, Day, Year)		
- 0	· Ethers hards	D07857		8/30/99			
	30. Nama and address of person who completed cause of death (II		MD 21740				
	Edson Moody M.D., 1190 Mr. Ad	etha koad. Hagersrown.					
State Registrar	Edson Moody M.D., 1190 Mt. A. 31. Date filed (Month, Sur Year) 7 1999						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Loate of Death Month Dey Year September 17,1499 September 4c. County of Death nt's Name (First, Middle, Last) ENA7 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 6336 Cedar Lane. Apt. 327 Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 050-22-7155 7. Age (In yrs. last birthday) 76 Yrs. 8. Dete of Birth (Month, Day, Year) Sept. 22, 1922 Birthplace (State or Foreign Country) Germany Days 1 M 2KN Months **Usual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Howard Columbia 1X Yes 2 No 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 6336 Cedar Lane 21044 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Merital Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specity: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Otto Klepper Erna Gertrude Eichoff 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela T. marsh, Daughter 5600 Catholic Church Rd., Jefferson, Maryland 21755 20b. Place of Disposition (Name of competent, cremetory or other place) Smithsburg Crematory Sept. 20, 1999 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. liused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated that initiated events resulting in death) Last Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 700 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred

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To the Funeral Director: Afte completely filled in by the fun edical

Physician /Medical

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25. Was case referred to medical examiner? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

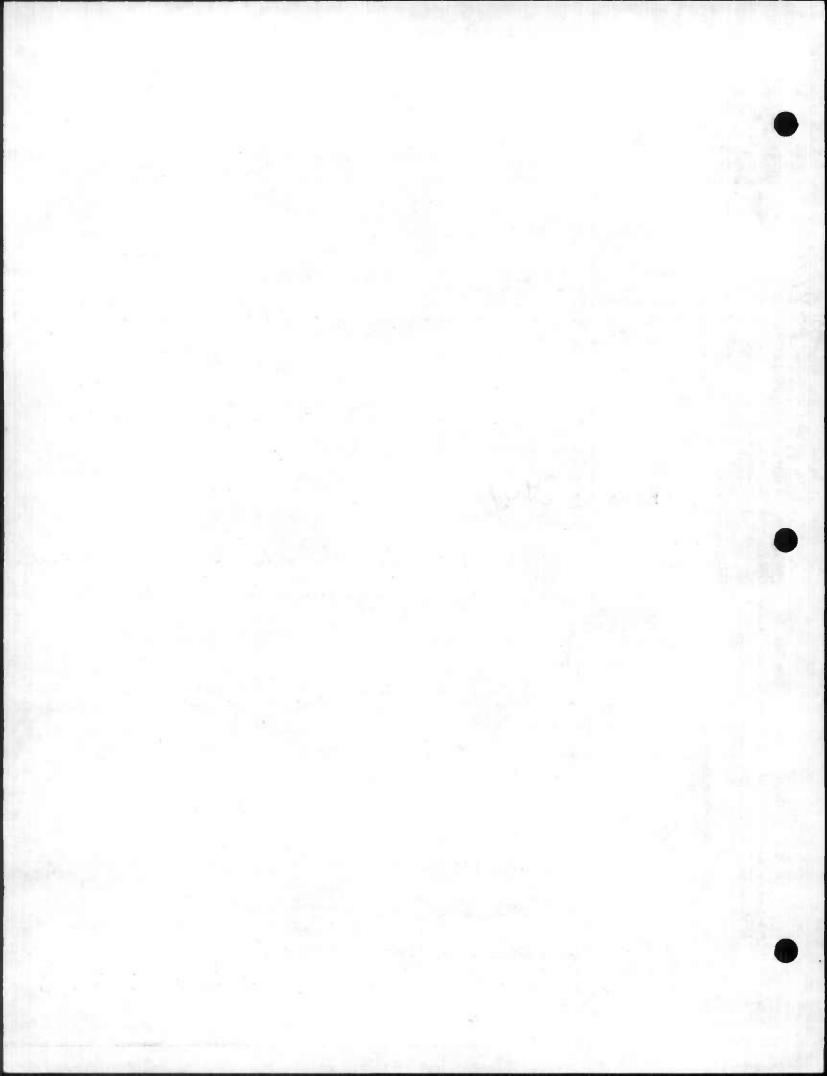
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

32. Registrar's Signature 1999

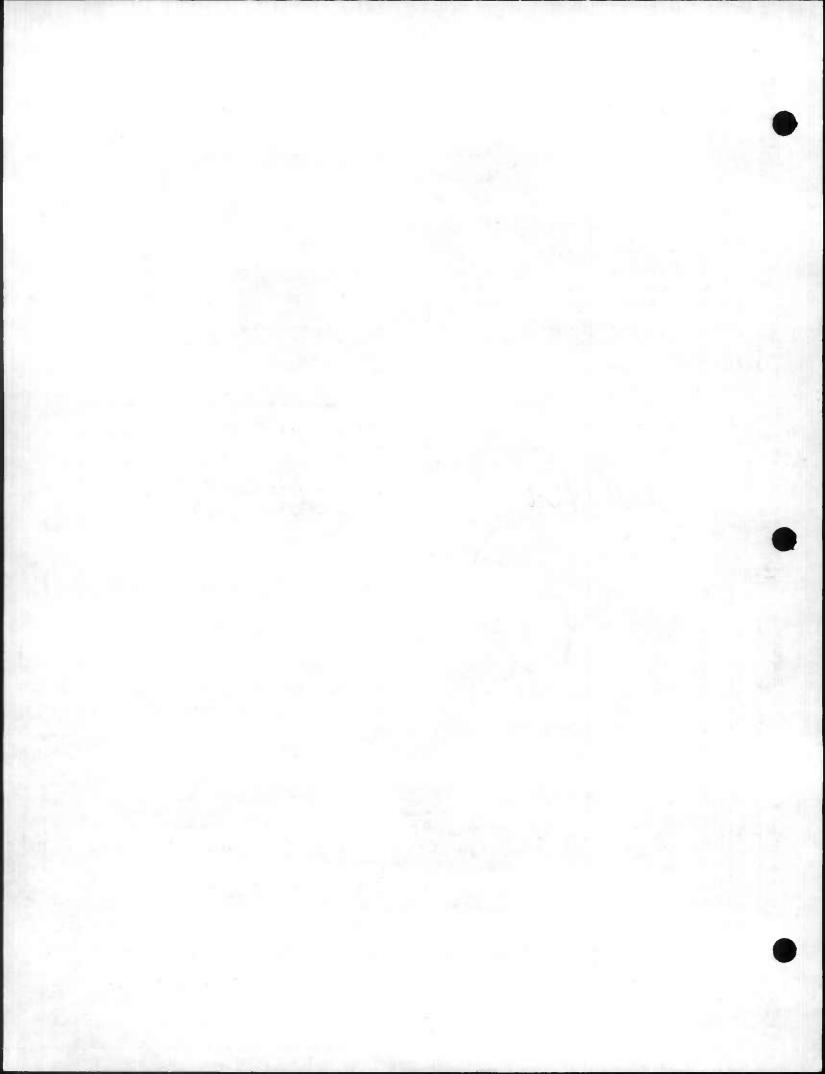
State Registrar



State of Maryland / Department of Health and Mental Hygier

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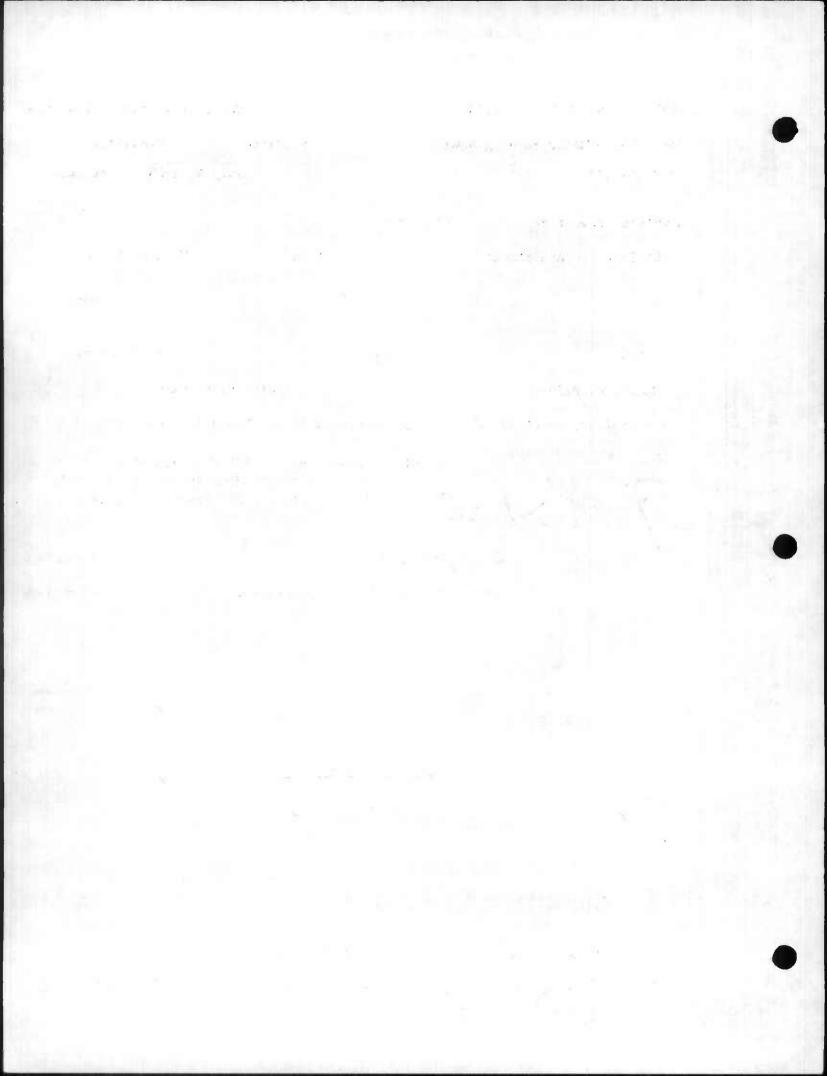
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State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** PEARL ADALINE TITUS Sept. 15, 1999 1:47 A.M. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not Institution, give street and number) **Examiner** Northampton Manor Nursing Home Frederick Frederick Birthplace (State or Foreign Country) ff Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey, Year) If Undar 1 Yaer 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. lest birthdey) **Funeral** 1□ M 2Ø F Months Deys Yrs. July 4, Maryland 217-10-0375 Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or edical Examples (must be 21702 United States permit. Pages 1 and 2 should be filed within 72 hours aftar deeth v
Department of Heelth end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 29a
and injury or other traumatic event, the Medical Example. 101 East Seventh Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yes, Giva Yaar or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - American Indien Bleck, White, atc. 1 □ Navar Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify. þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collage (1-4or 5+) Everedy Company 6th Inspector 18 Mother's Nama (First Middle Meiden Sumeme) 17. Father's Name (First, Middle, Last) Amelia E. Plunkert George D. Wiles 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informent's Neme/Reletionship (Type, Print) Frederick, Maryland 21701 Joan Hopkins, great niece 7306 Westwood Drive 20a. Method of Disposition 20b. Plece of Disposition (Neme of camatary, cramatory or other pleca) Date 20c. Location - City or Town, Stete *XBurial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 9/17/99 Frederick, Maryland Olivet Cemetery e of Editoral Service Liconsee 22. Name end Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 Approximete Intervel Batwaen Onset end Deeth weth. Do not enter the mode of dying, such as cardiec or respiratory arrest, **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Due to (or es e consequence of): Examiner Physician/Medical Examiner Cerebrovascular Disease physician and the burial-transit The law requires that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or injury Due to (or es a consequença of) O. Box 68760. thet initiated events resulting in daeth) Lest Due to (or es e consequence of): ettending p 88 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ۵ Division of Vital Records, by 24b. Ware autopsy findings aveileble prior to completion of causa of daeth? should b 24e. Wes en eutopsy performed? Completed cartificete has b 1 ☐ Yas 2 ☐ No 1 Yas 2 No or Attending Physician: after death. 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatiant 2 ER/Outpetient 3 DOA this funeral 27. Mannar of Death 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Neturel 5 Pending 1 Yes 2 No investigation within 24 hours after death To the Funeral Director: / completaly filled in by the (2 Accidant 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida 29a. Certifiar 🗺 Certifying Physician: To the best of my knowledge, deeth occurrad at tha tima, data end pleca, end due to tha causa(s) and menner as statad. edical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29d. Data signed (Month, Dey, Year) 29b. Signatura end title of certifian 29c. Licensa number 0 9-15-99 MTol MD MD 51610 ~~ 30. Nema end addrass of person who completed causa of death (Itam 23e) (Type, Print) Frederick, MD 21702 204 Aue Tanen Suite 31. Dete filed (Month, Day, Year) 32. Registrar Signature State **7** 1999

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Rodney September 18, 1999 Woodrow Tomas 6:51 PM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 24, 1914 9. Birthplece (State or Foreign **Funeral** Months Days Hours 10 M 20 F Country) Maryland Director 278-03-0528 85 Usual Residence of Deceden the Meryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hame 23s or 28s-f show the Medical Examiner must be notified at XXYes 2 No Director Walkersville Maryland | Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours effect deeth. Department of Heelth and Mentel Hygiens. Important: If item 27 is marked other than "natural", or farms 28a and hijury or other treumatic event, the Medical Experiment 2008. 21793 United States Apt. 103 200 Chapel Court Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: P White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 8th Frederick Mem Hospital Security Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B Charlotte Elizabeth Rice Ernest Toms 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Walkersville, Maryland 21798 Catherine Isabelle Tomas, wife 200 Chapel Court #103 2(lb. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 9/21/99 Libertytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Union Chapel Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Lipetisee Walkersville, Maryland 21793 40 Fulton Avenue 23. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, 1045 Physician/Medical Due to (or as a consequence of) for use es . The lew requires that the death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? \$ signed by 1 d be detect 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Were autopsy findings available prior to bloods 24a. Was an autopsy performed? Completed completion of cause of death? = 1 🗆 Yes 2 2 No 1 Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? director, 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA shis. After this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 (Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certiff 29d. Date signed (Month, Day, Year) 29c. License number 8 30. Naš cause of death (Item 23a) (Type,

State Registrar

31. Date filed (Month, Day, Year)

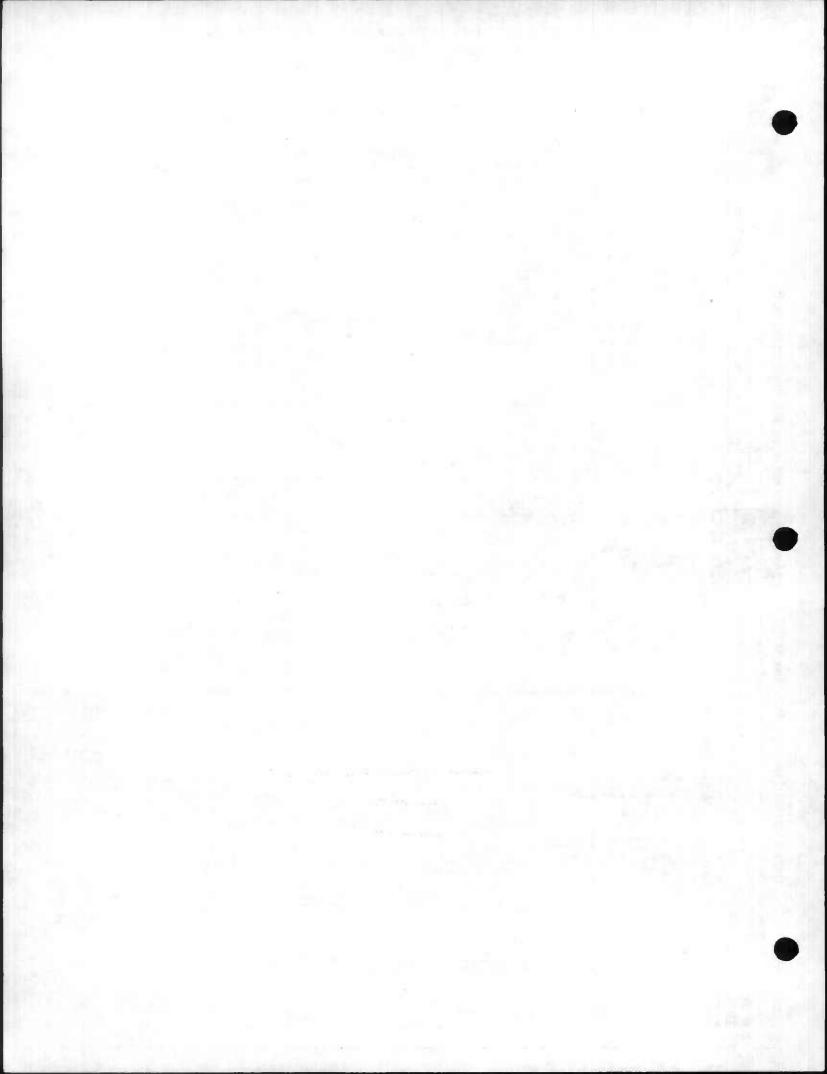
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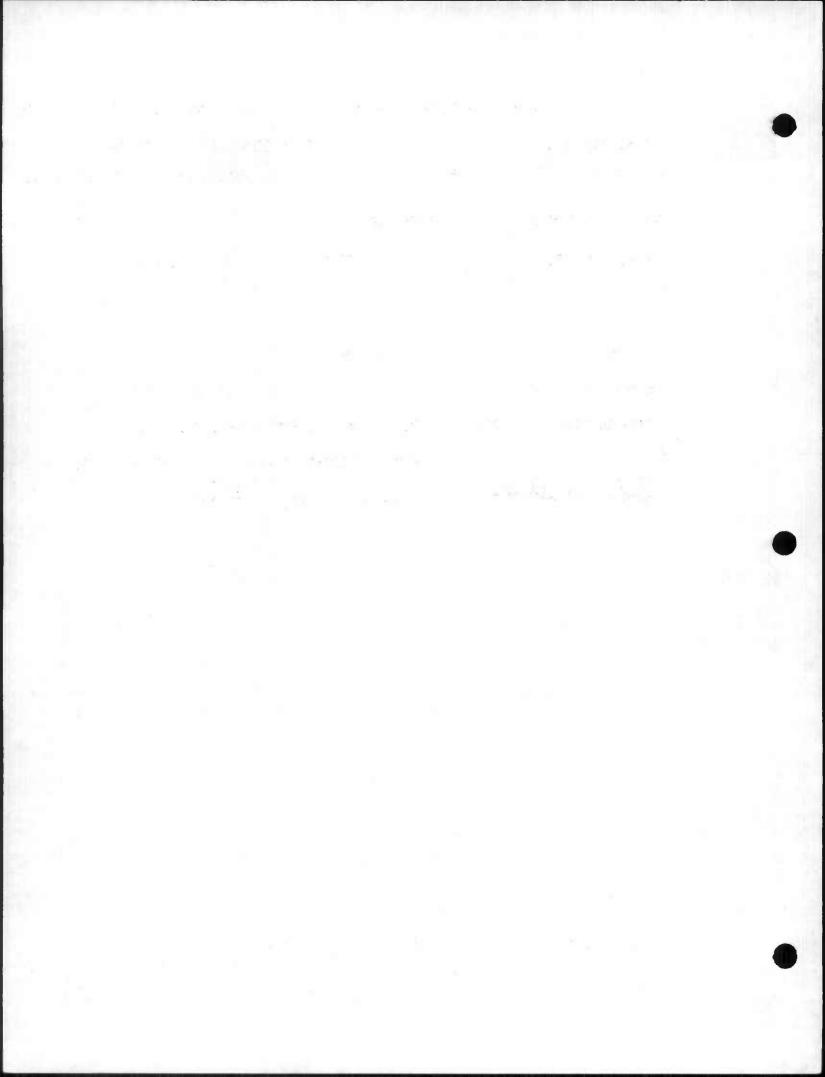
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:15 AU JOHN CHRISTOPHER WARTHEN SEPTEMBER 1, 1999 /Medical 4e. Fecility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** EMMITSBURG If Under 24 Hrs. 8. C 510 W. MAIN ST. If Under 1 Yaar 5. Sociel Security Number 8. Data of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days 100 M 2□ F Yrs. 216-60-8665A Director JAN.9.1954 GETTYSBURG, PA. Usual Residence of Deceden death with the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or Items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at 1 X Yes 2 No Director MARYLAND FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 W. MAIN ST Funeral 21727 U.S.A. 12. Was Dacedanf Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Yeer or Detes: Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) Race - American indien, Bleck, White, etc. 1 Nevar Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed withit.
Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than any Injury or other traumatic accept. Elementary/Secondery (0-12) College (1-4or 5+) DISABLED 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Sumeme) Be JOHN LOUIS WARTHEN KATHLEEN JONES 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KATHLEEN WARTHEN P. O. BOX 135, EMMITSBURG, MD. 21727 MOTHER 20b. Piece of Disposition (Neme of cematary, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 Ø Buriai 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) EMMITSBURG MEMORIAL 9/4/99 EMMITSBURG, MD. 21. Signature of Funerei Sarvice License 22. Nama and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 Enter tha disease, or *com*plications that caused the death. Do not enter the *m*ode of dying, such as cardiac or raspiratory arrast, or haart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner burial-transit Sequentielly list conditions, if eny, laading to immedieta cause. Enter Underlying Cause (Diseese or Injury that initieted events rasulting in deeth) Last and physician a Division of Vital Records, P.O. Box 68760, Physician/Medical Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did-tebacco use contribute to the cause of death? signed by t 2□ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Derformed? Completed peen s 50 certificate 1 ☐ Yes 2 ☐ No 20 4 25. Wes case referred to medical examiner? To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetienf 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending Investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - Af home, ferm, straet, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, deta end place, and due to the cause(s) end mennar stated. Medical 29e. Certifian 29b. Signature end litie of certifier 29c. Licensa numbar 30. Nema and address of person who completed cause of deeth tem 23a) (Type, Print) ERI

State Registrar



Division Attending 24 hours after death.

3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 1 PYes 2□ No 28d. Describe how injury occurred SUBJECT 5 Panding investigation 1 ☐ Yes 21 No 9-3-99 UNKNOWN 2 Accident INGESTED NARCOTIC & COCAINE Could not be determined 3 Suicide 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Numbers or Rural Flours Numbers K City or Town, State) JIZ BRUNSWICK 4 D Homicide HOME BRUNSWICK, FREDERICK CO. 29a, Certifier 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner as stated. (Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end place, and due to the cause(s)

State Registrar 32. Registrer Signeture

Neme and address of person who completed cause of death (Item 23a) (Type, Print) well

1999

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

September 4, 1999

29c. License number

O.C.M.E.

within 24 hours after To the Funeral Directory

edical

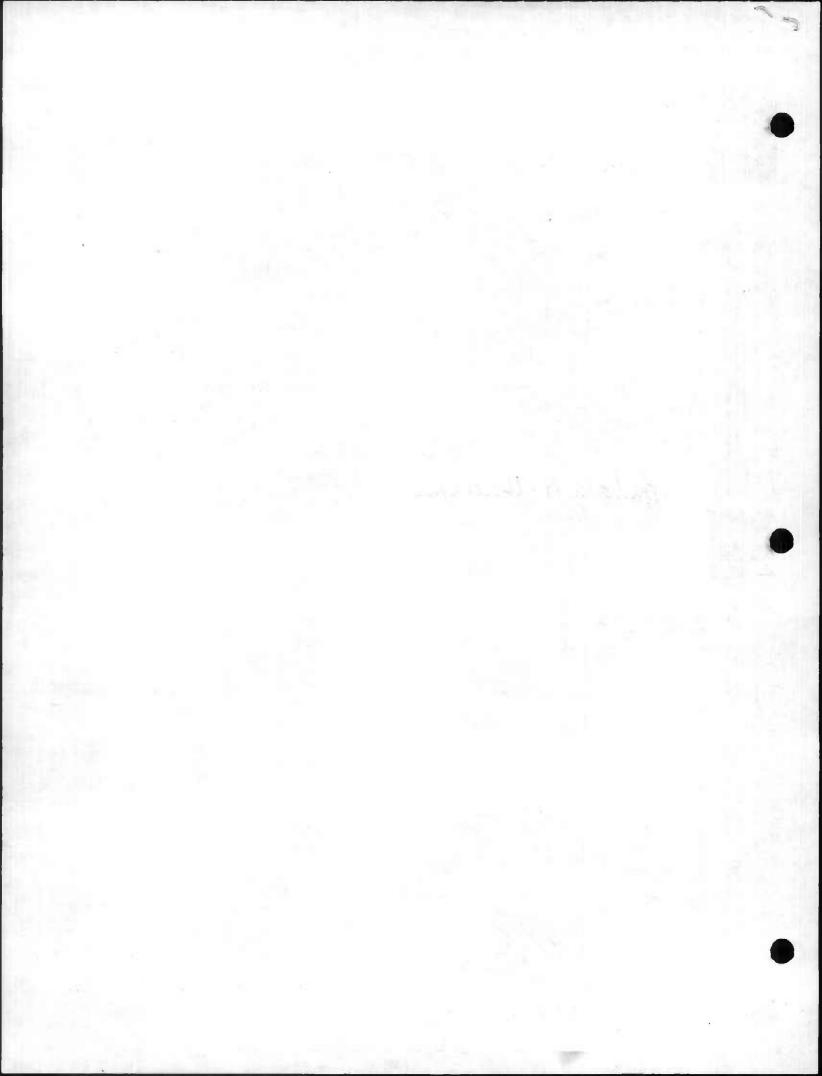
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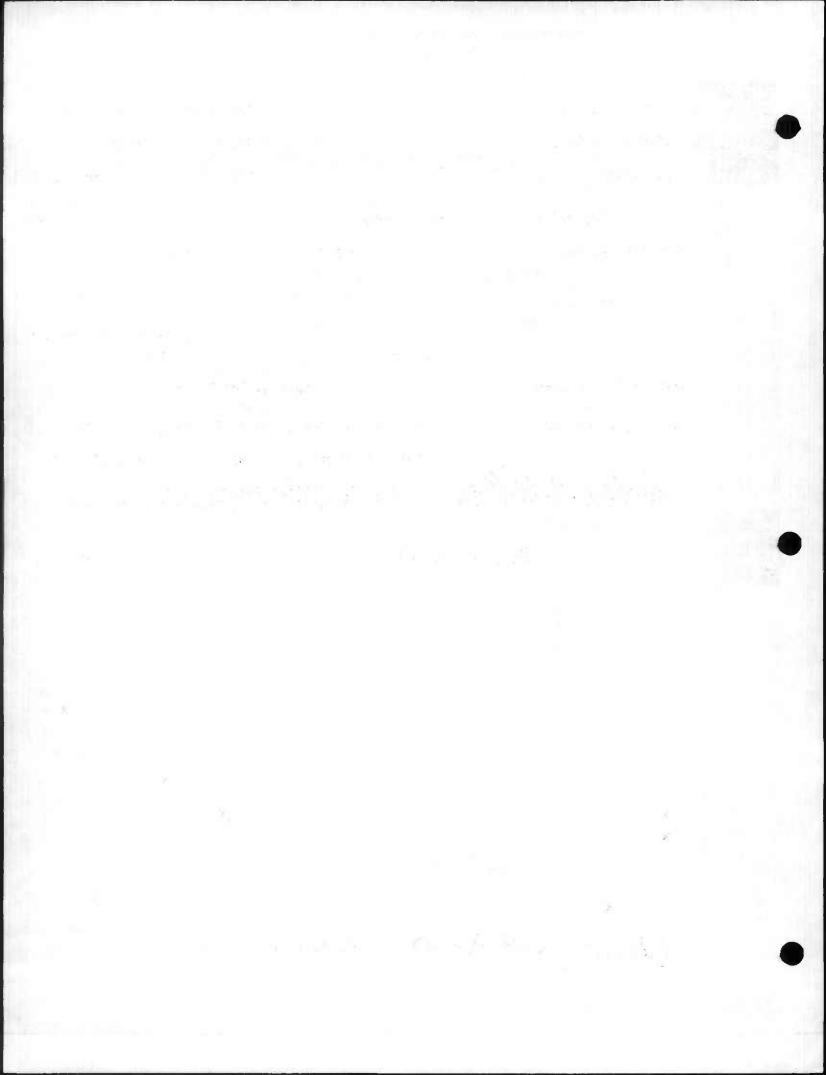
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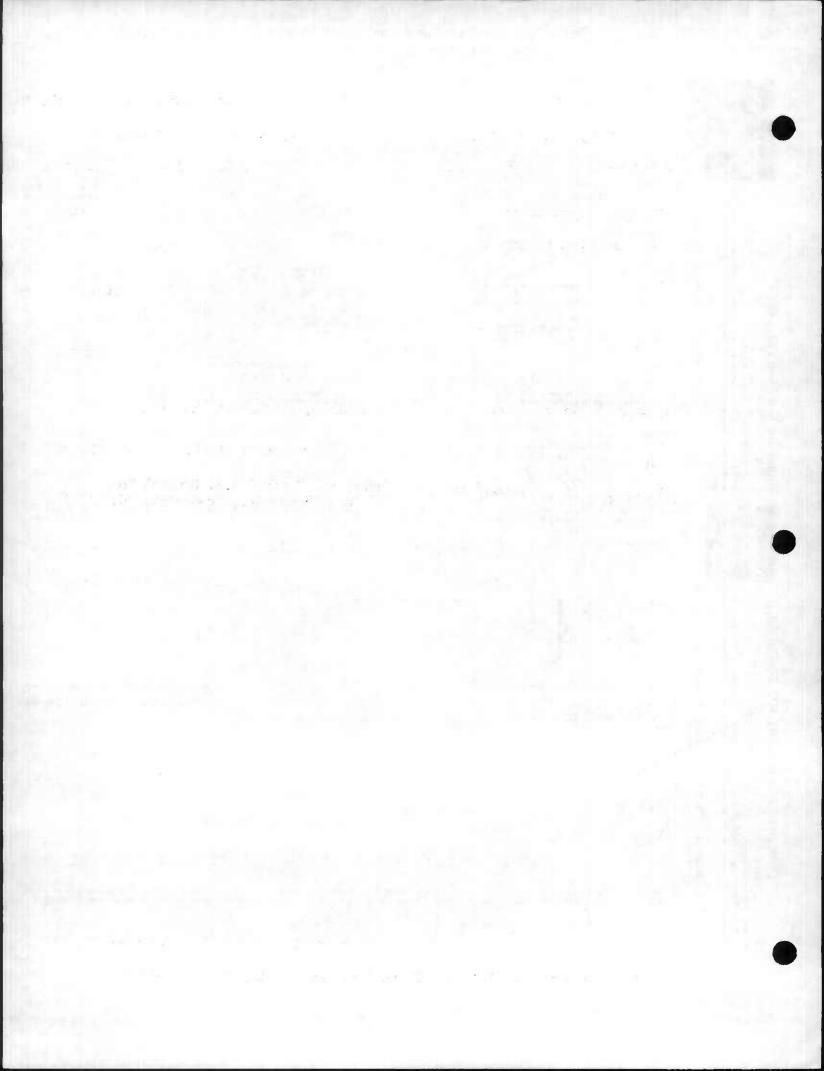


State of Maryland / Department of Health and Mental Hygiene Q

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	State Registrar	31. Dete filed (Month, Day, Yea	P 2 3 1999	Registrar's Sign	ature	16.		60	,					
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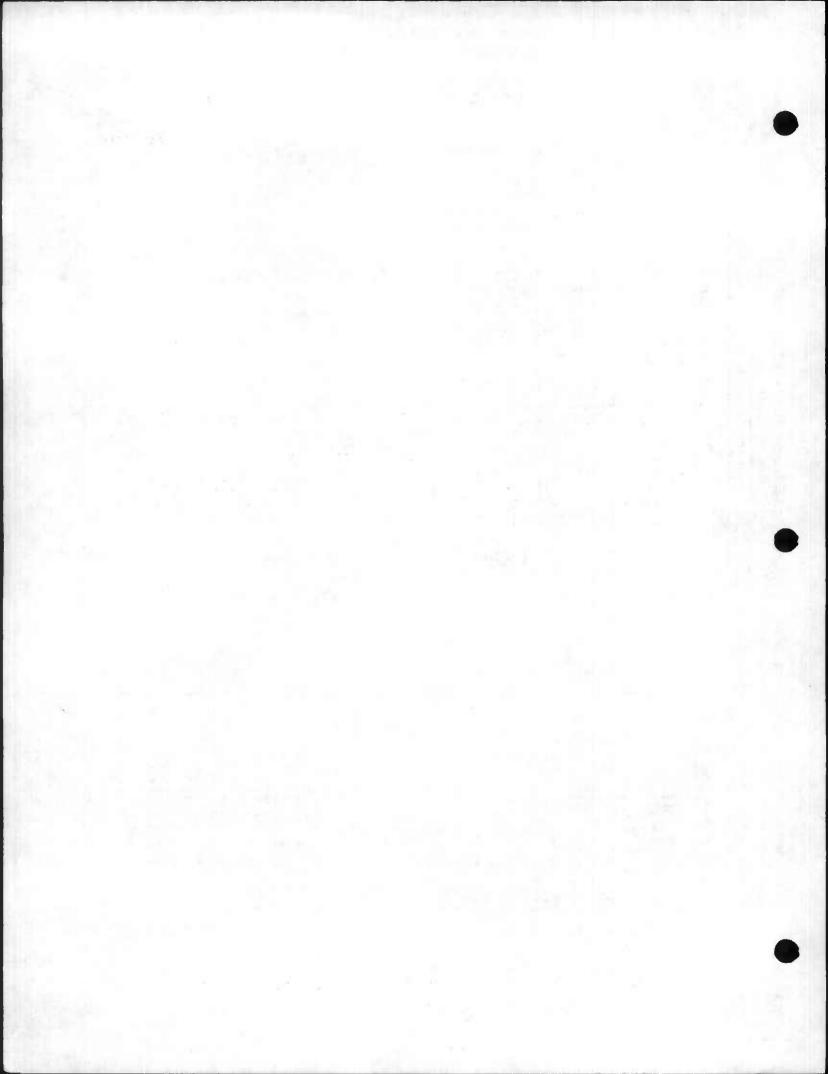


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 9:04 AM 1. Decedent's Name (First, Middle, Last) 2. Data of Death September 24, 1999 Edna Virginia Younkins **Physician** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4636 New Design Road Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State (Month, Day, Year) | 1927 | Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF 219-20-3904 Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehome** r than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 No Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4636 New Design Road 21703 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes AIX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. Ither then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Partner/Bookkeeper permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Physiens Important: If tem 27 ie marked other tha any injury or other treumatic event, the page. Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 8 William H. Main, Sr. Flora Carpenter 19a. tnformant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Austin A. Younkins, Husband 4636 New Design Road, Frederick, Maryland 21703 20a. Method of Disposition

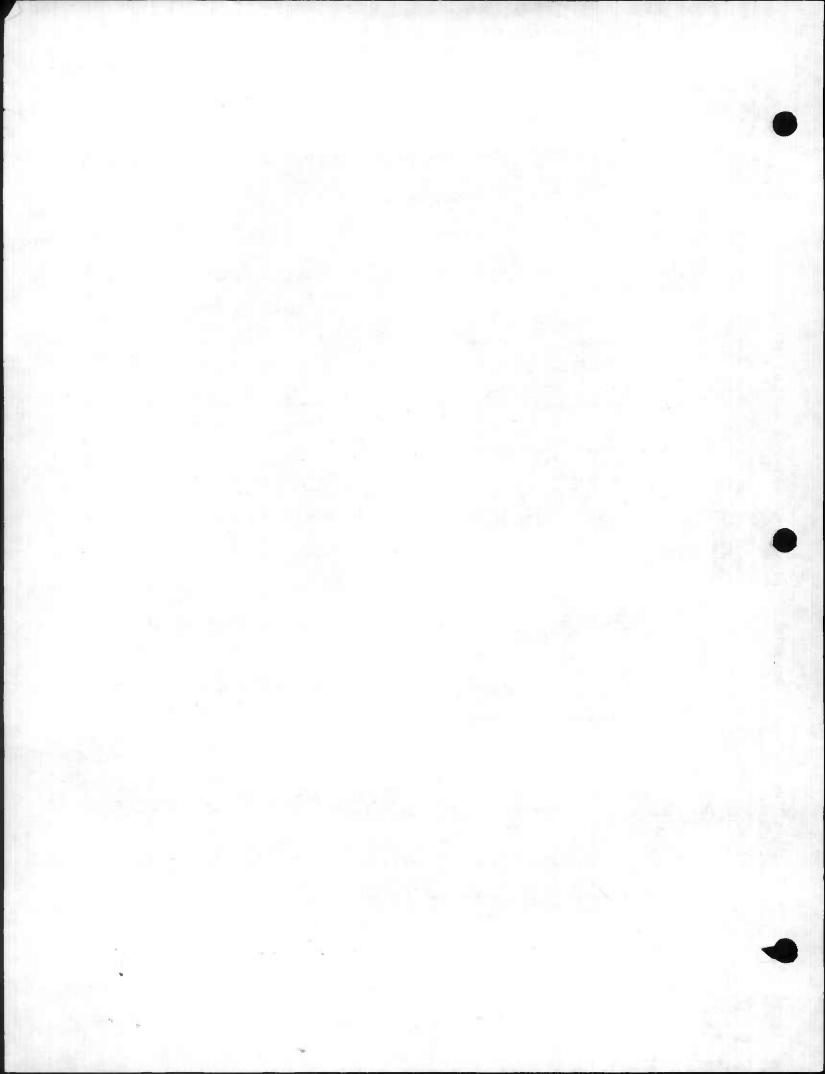
14 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, State Mount Olivet Cemetery, Sept. 27, 1999 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service License 22, Name and Address of Facility. Keeney and Basford P.A. Funeral Home MO0255 106 East Church St., Frederick, Md. 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** Metastatic Colon Concer. months /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examin strending physician and for use as the burlal-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to been si 24a. Was an eutopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 Tyes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 22 No Other: 4 Nursing Home 6 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera Affer Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 29b. Signilly he and 29d. Data signed (Month, Day, Year) title of certifier 29c. License number A.Z. HEGAZI, MD September 24, 1999 D 44164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amr Zakaria Hegazi MD 801 Toll House Ave., Frederick, Maryland 21701 31. Date filed (Month, Day, Year) 32. Registrar Signature State SEP 2 7 1999 > Spark) Registrar



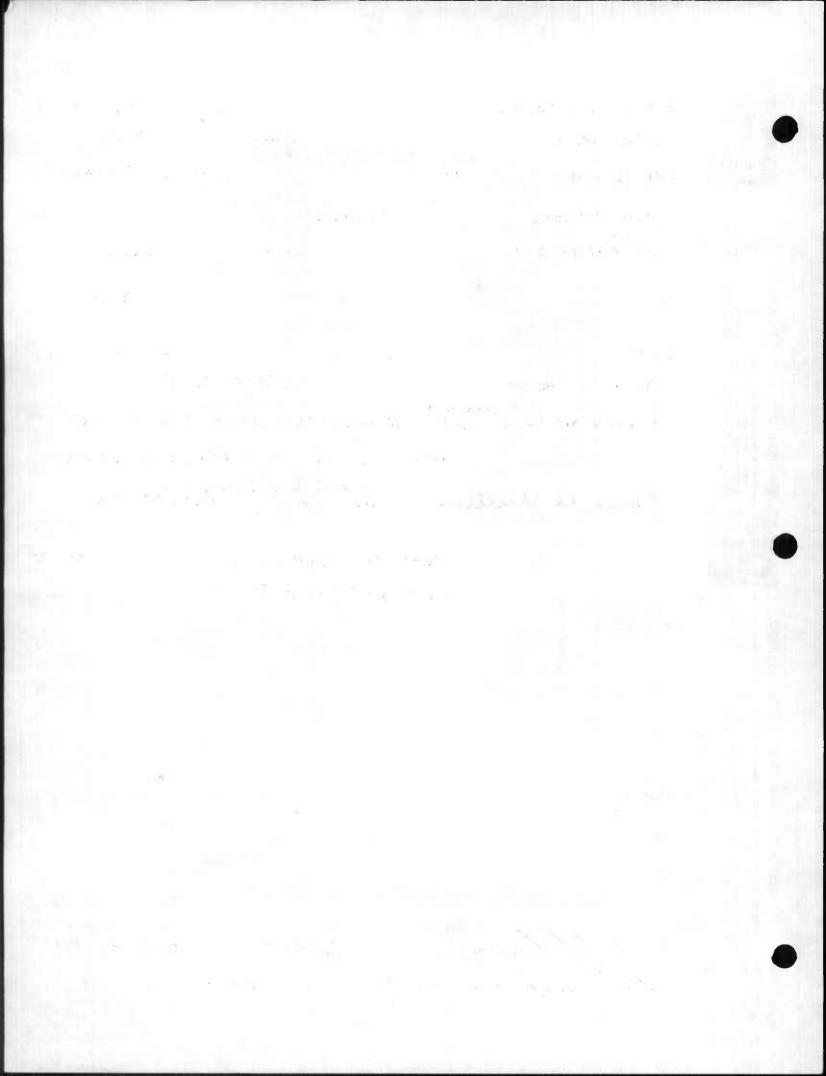
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician 1999 Laura V. Archibald 8:45 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 259 Mallard Drive Pasadena Anne Arundel 8. Date of Birth Month Day Year) 915 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
I'ld y land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 F 84 Yrs. 218-42-4290 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 20XNo Director Anne Arundel Maryland | Pasadena 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 259 Mallard Drive 21122 USA death 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, alc. filed within 72 hours after thygiene. 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 200No Specify: White Specify: py 3 K Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household. permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked oths eay Injury or other traumatic event, pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oliver Duvall Laura Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul N. Archibald (Son) 259 Mallard Drive, Pasadena, MD. 21122 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Glen Burnie Cemetery Glen Burnie, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain RD. Pasadena, MD. 21122 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest only one cruse on each line. Approximete Interval Between Onset and Death **Physician** Atherocaleratic Heart Immediate Cause (Final disease or condition resulting in death) /Medical -44 lars Examiner Afual Fibri Va Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician for use as the burla Box 68760. Due to (or es a conse P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ρA Mospital or Attending Physician: The law requires to 24 hours after death.
 Function of the continue of the period of the best of the best of the best of the best of the best of the function of the best of the functal director, page 2 should be best by the functal director, page 2 should be. 24b. Were autopsy lindings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 PNo 1 ☐ Yes 2 € No Division of Vitai 25. Was case referred to medical examiner?

1 2 Yes 2 No Be 26. Place of Death (Check only she) Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 DNatural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completaly filled in by th Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00038912 ala 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1720 Crain Highway Purfe 204 SALVACION RAMIREZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

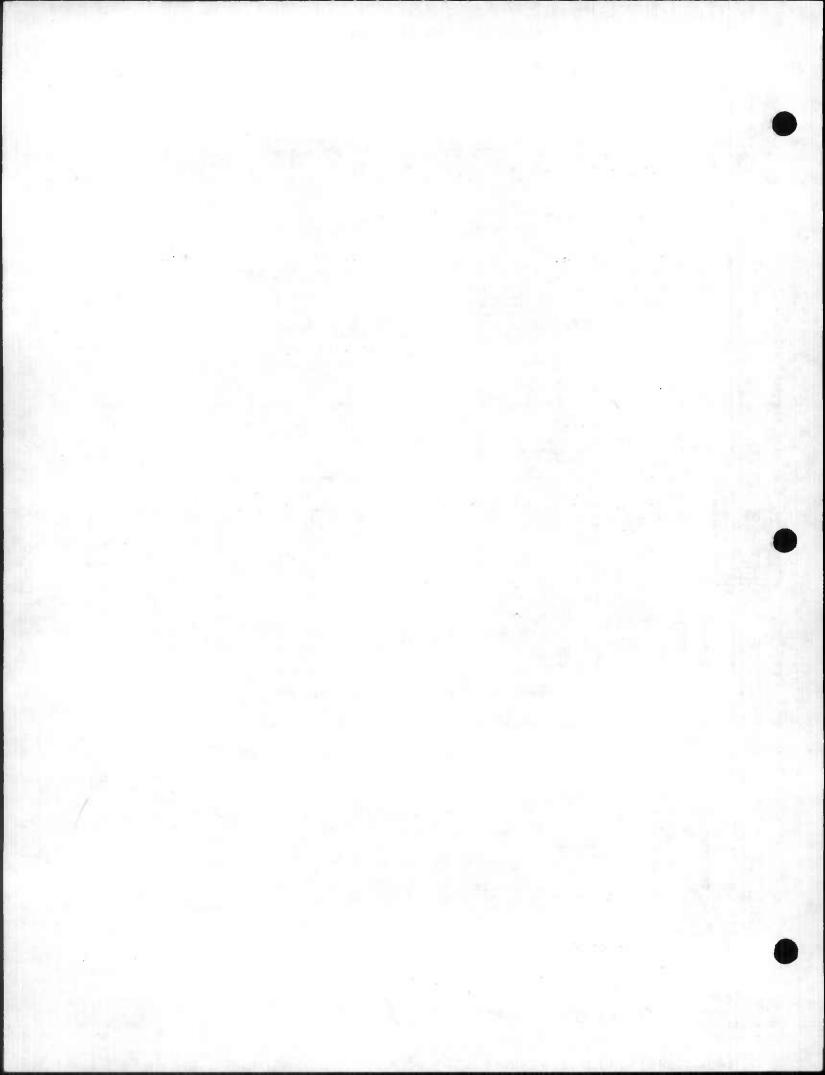


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 4 AM ELSIE BOOTMAN 10 10 99 /Medical 4e Fecliity Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Clarksville Howard Hillside House If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 9. Birthplece (Stete or Foreign 7. Age (In yrs. lest birthdey) **Funeral** 1□M 2♥F Yrs. 214 - 18 - 550 Usuai Residence of Decedant 87 Maryland **Director** 4-30-12 permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural, or items 23s or 28s-f show any Injury or other traumatic event, in Medical Examiner must be notified as 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Baltimore Maryland Directo 10e. Street end Numbe 10f. Zip Code 10g. Citizan of Whet Country? 21236 4119 Kahlston Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No 14. Raca - American Indian, 11. Meritei Stetus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorcad Completed 16e. Decedant's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) Cotiege (1-4or 5+) 8th Grade Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Martha E. Handel Richard Max Melzer 19a. Informent's Neme/Reletionship (Type, Print) (Personal 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) 9446 Garnett Lane, Ellicott City, MD Mr. Lou N. Reinthaler Rep.) 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriat 2 ☐ Cremetion 3 ☐ Removal from State 10/16/99Baltimore, Maryland Parkwood Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician /Medical immediete Ceuse (Finet diseese or condition resulting in daath) myouprilite inforcessan Examiner Morkey DIJEBE Examiner (OROMPHY physician and the buriel-transit Due to (or es e consequenca of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaasa or Injury P.O. Box 68760, The law requires that the death certificate be Physician/Medical that initieted events resulting in deeth) Lest Due to (or es e consequenca of): S use Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 € Unknown Division of Vital Records. by 24b. Ware eutopsy findings evellable prior to completion of cause of death? 24a. Was an autopsy Completed ate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
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 Funeral Director: After this certifice funeral director, 25. Wes case rafarrad to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residance 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No 28e. Data of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Place of tnjury - At home, ferm, street, fectory, office building, atc. (Spacify) completely filled in by 4 Homicide UM Certifying Physician: To the best of my knowledge, deeth occurred at the tima, data end place, and dua to tha ceuse(s) end menner as stated.
2 ☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daeth occurred et the time, date and place, and dua to tha causa(s) and manner statad. 29a. Certifier edical To the To the To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddrass of memory who completed cause of death (Itam 23a) (Type, Print) The apry RD CLARUSVILLE MAY 210 29 Stergor 5540 m 31. Dete filed (Month, Dey, Year) 32. Registrat's Signeture OCT 13 Registrar



	Decedent's Name (First, Middle, La.	st)		artment of I tificate of			eg. No. 99	3. Time of Death			
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Examiner Funeral Director	3312 FLEET S	TREET	yrs. last birthday) 2 Yrs.	If Under 1 Yeer Months Days	BALTIMO		N/A Year) 9. Birtl	hplece (Stete or Fore untry) W. VA			
	Usual Residence of Decedent 10a, State 10b, County	1100	. City, Town or Lo	ostion				10d. Inside City Lim			
a how	MD. N/		BALTIM				Mark I	t XYes 2□			
or 28a-f e be nouned Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Whet Co	untry?			
23a or al Di	3312 FLEET ST			2122	24		USA				
ar, or Home remover m by Funer	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub I ☐ Yes 2☑ No	Hispanic Origin? (S san, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: WH	e, etc.			
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Con Con	6		CHEC	KER/REC		453 . 443 4 9	NATIONAL	CAN			
	17. Father's Name (First, Middle, Last) THOMAS J. BAL.					ne (First, Middle, M RUNNER	Maiden Sumeme)				
f Health and Ments tem 27 is marked other treumatic a	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Stree			, City or Town, State, 2	(ip Code)			
Health a arn 27 le ither treu	MARIE BALL/WI	FE	3312	FLEET	ST., BA	LTIMORE	MD.212	24			
of Hear	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐		b. Place of Dispo	sition (Name of netory or other ple	ece)	Date	20c. Location - City or	Town, State			
ant: H ury or	4 ☐ Donation 5 ☐ Other (Specifi	1)	OAK LAW	N CEME	rery 1	0/11/99	BALTIMO	RE, MD.			
Department of Important: If I eny Injury or price.	21. Signature of Funerat Service Licer 23a. Part1. Enter the disease, or comshock, or pear failure. List only	1 / - 1	0 0	HARLES	C PRIT	ER & SC	ON, INC.	MD. 212			
Medical xaminer of caracteristics of the butterfrancial caracteristics of the butterfrancial caracteristics of the caracteristics of	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rignry that initiated events resulting in death) Last	b. C.O.	to (or as a consector (or es a consector or establishment or	uence of):	IS BAS		Carc				
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page 2 should be de Completed by F						24a. Wes a perform	24a. Wes an autopsy performed? 24b. Were eutopsy finding availeble prior to completion of caus of deeth?				
certificate has rector, page 2 Be Comp						1 Yes 2 No 1 Yes 2 No					
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을 보고 다	1 Y 2 No 27. Manyler of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury		Home 5 Mesidence 6 Other (Specify) 28d. Describe how injury occurred						
rs effer death. el Director: Affer t led in by the funera Certification:	3 Suicide 6 Could not b	28e. Place of Injury - building, etc. (Sp	set, fectory, office	281. Location (Street and Number or Rural Route Number City or Town, State)							
24 hour Funer etely fill		ysician: To the best of my niner: On the basis of exar and manner steted.									
in the					se number	1 2	9d. Date signed (Mont	h Doy Year)			
To the comple	29b. Signature and the of certifier	e Dee		29c. Licen	563	Sp.	10.8.	99			



State Registrar

DHMH 16 Rev 6/95

(Month, Dey, Year) QCT 13 1999

29b. Signature and title of certific

30. Neme end address of person while

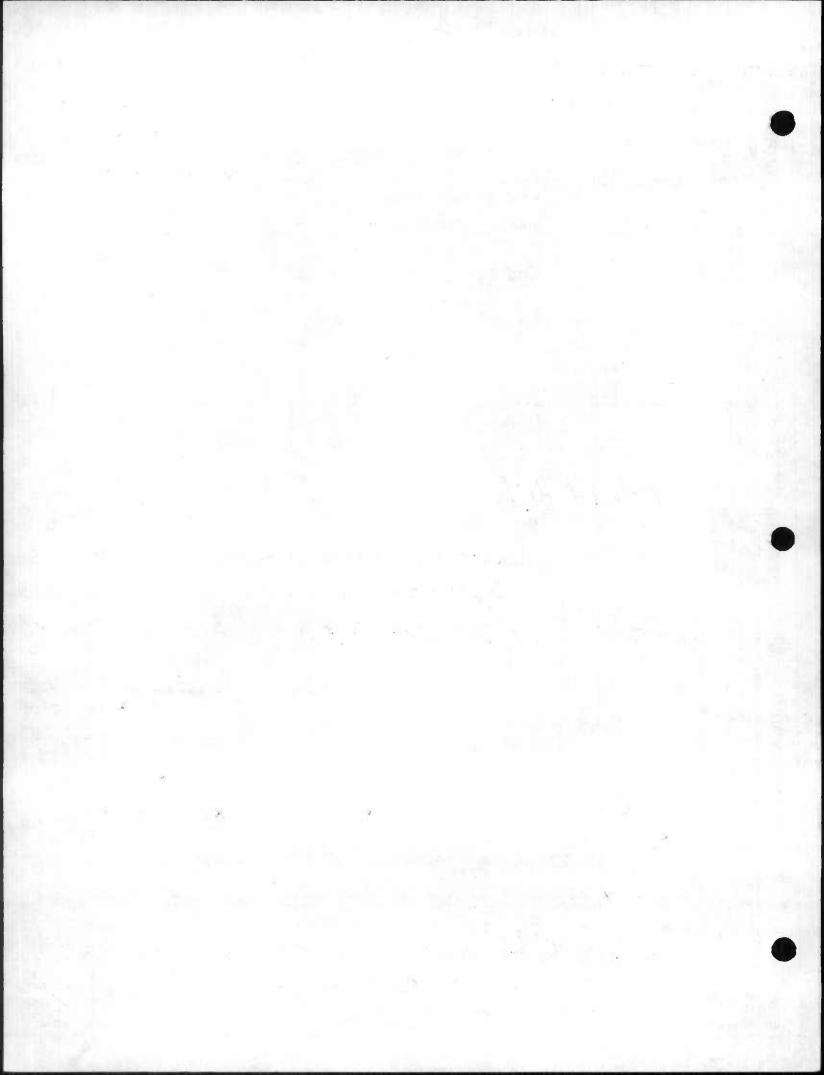
32. Registrer's Signature

medied cause of death (Item 23a) (Type, Print)

29c. License number

29d. Dete signed (Month, Day, Year)

erna Medicine Water Rec



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month AME 2:07 PM 10 4a. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth JESSUP MARY LA.
5. Sociel Security Number OF ORR ECTION JESSUI ANNE LAN. ARUNDEL 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, 1. M M 2□ F 216-40-1988 Usuel Residence of Decedant 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits MD 1 Yas 2 No Anne essup 10e. Street and Number UNK 10f. Zip Code UNK 10g. Citizan of What Country? USA 12. Wes Decedent Evar in U,S. Armed Forces? 1 Yes 22 No If Yes, Give Yeer or Detes: 11 Meritei Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 Nevar Married 2 Merried 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) College (1-4or 5+) B+O Railroad Track Switcher 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Armstrong harles Brown orrine 19a. Informent's Name/Ralationship (Type, Print) mother 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Brown Apt. 308 Baltimore, mo. 21227
Data 20c. Location - City or Town, State 3310 Benson Avenue orrine 20b. Place of Disposition (Neme of cemetery, crametory or other plece) 20e. Method of Disposition 1 Burlei 2 □ Cramation 3 □ Removel from State Memorial Park Oct. 12 Baltimore, mo 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 5 Other (Specifi Memorial 4 Donetign 21. Signeture of Funeral Service Lice Farti. Enter the disease, or complication it it caused the deeth. Do not enter the mode of hing, such as cardiac or ras liretory arrast,

Approximate Approximate Interval Between Onset and Deeth immediate Cause (Final CARDIO PULMONARY ARREST

Due to (or as e consequence of): disaesa or condition resulting in death) Sequentielly list conditions, if any, leading to immadiate causa. Entar Underlying Couse (Disaese or injury that initiated avents resulting in deeth) Last Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy tindings available prior to completion of causa of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Panding 1 ☐ Yes 2 ☐ No

Box 68760. Division of Vital Records, P.O.

t or Attending Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the attending physician and been signed by the attending physician should be detached for use as the buria To the Hospital or Atter within 24 hours effer dea To the Funeral Director completely filled in by th

Physician /Medical

Examiner

Physician/Medical Completed by Be Certification: To

Physician

/Medical

Director

Funeral

Completed by

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Examiner

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Director

permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland

25. Wes case referred to medical

27. Menner of Deeth 1 Natural

2 Accident 3 ☐ Suicide 4 - Homicide

29e. Certifier

(Check only one)

investigation 6 Could not be

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

281. Location (Street end Number or Rural Routa Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and menner stated.

29b. Signeture end titla of cartifier M.D 29c. License number

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

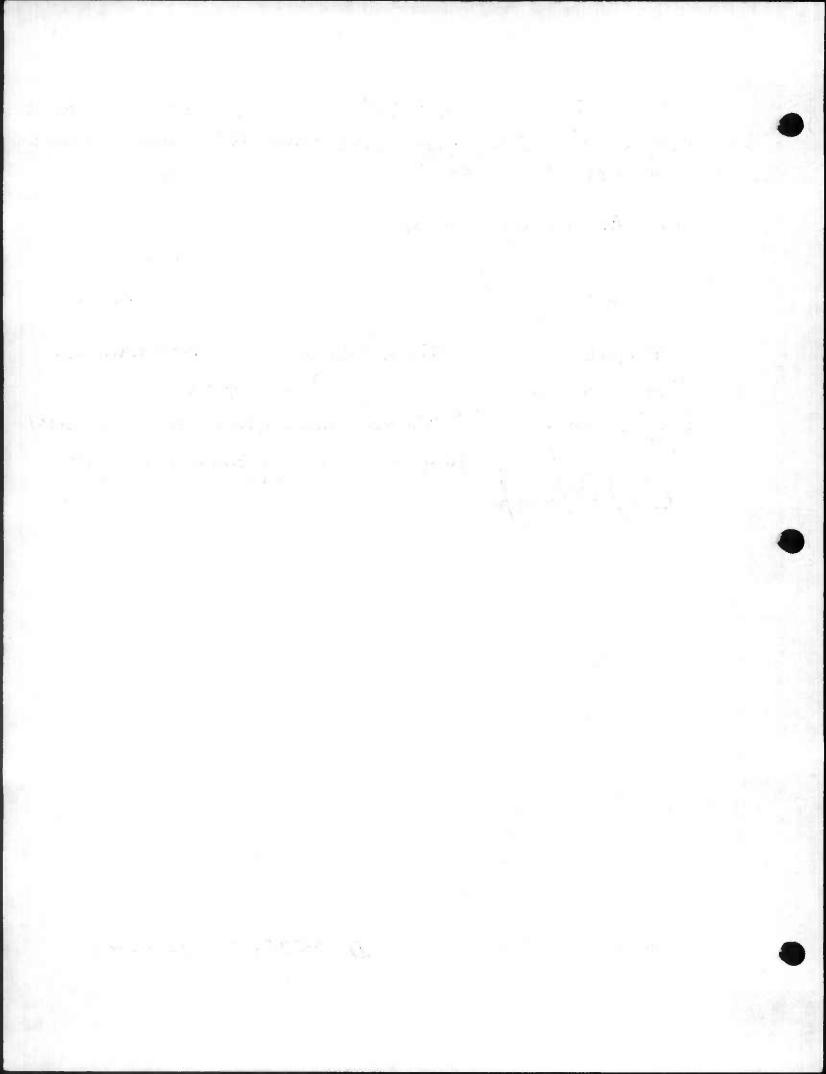
Aya W. MARYLAND HOUSE OF CORRECTION

31. Dete filed (Month, Dey, Year) State Registrar

Medical

13 OCT

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nema (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** TEORG 0 10 99 12:15 pm 06 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FORT HOWARD MD 21052 FORT HOWARD BALTIMORE 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months 10 M 20 F 79 Director 217-05-4692 Usual Residence of Deceden the Maryland 10e. Stata 10b. County 10c. City Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Нета 23а Funeral 1. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian. Bleck, White, etc. filed within 72 hours after Specify: BlAck 1 Never Merried 2 Merried Maryland 21215-0020 *naturaf, or 1 Yes 2 No If Yas, Giva Yeer or Dates: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ·E Ront q Department of Health and Mantal Hygiane. Important: If item 27 is marked other than any injury or other treumatic event, the Ma DRG. Elementery/Secondary (0-12) College (1-4or 5+) DORE 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fathere Name (First, Middle, Last) Be Pages 1 and 2 should be SROW 19e. Informent's Neme/Re lationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2/2/6 0 12 WAR Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stata 1 Burtal 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service License RR Name end Address of Fability

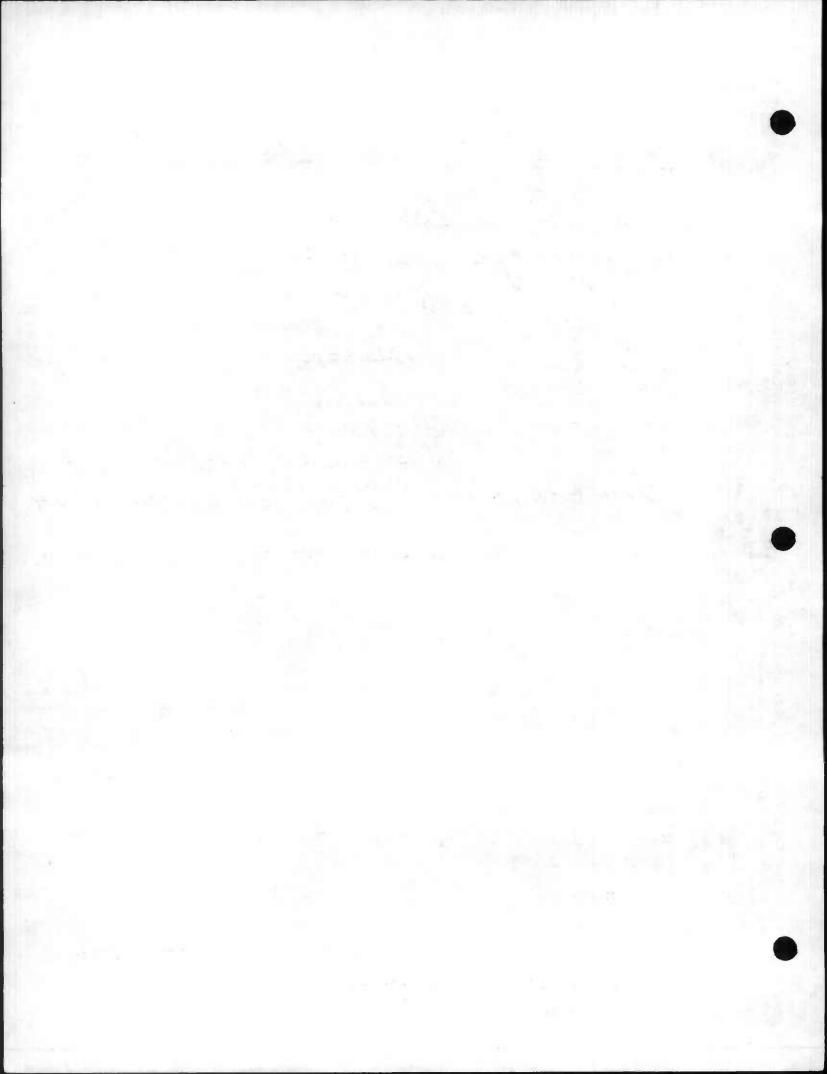
ARSA AT

410 | Edmon amond 23e. Pert1. Enter the disease, or complications that cau and the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. Approximete / Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Finel disaesa or condition resulting In daeth) PROSTRATE WITH METASTASIS 8 months Examiner Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medical the Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 1 No 1 Yes 2CXNo after death.

Director: After this certifica director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1K) Yes 2∏ No **†**O∮npatient 2 ER/Outpatient 3 DOA funerai 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Meturel 2 ☐ Accident 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by th 3 Suicide 28e. Plece of Injury - At home, ferm, street, lactory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signetuge and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 OCTOBER 6, D14958 MMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURORA C. TAN, MD. VAMHICS FORT HOWARD, MARYLAND 21052 31. Dete liled (Month, Day, Year) 32. Registrar's Signature State OCT 13

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Deeth Month 30 ZA 10 AM 4e. Facility Neme (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth 1543 Sulphur Spring Road Arbutus Baltimore 5. Social Security Number 7. Aga (In yrs. last birthdey) 76 Yrs. If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (Steta or Foreign Country) Days Hours 1 □ M 21 F 214-16-6224 Maryland Nov. 16,1922 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Sulphur Spring Road 1543 21227 United States 11. Marital Status 12. Was Decedent Ever in U,S Armad Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: Specify: 3 ☐Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Book Keeper 17. Father's Name (First, Middle, Lest) 18. Mother's Nama (First, Middle, Maidan Sumeme) Francis Russell Helen Tillery 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Debora Egitto (Daughter) 1543 Sulphur Spring Road Arbutus, MD 21227 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10/13/99 Catonsville. MD 21. Signature of Funerel Servica Licent 22. Name and Address of Facility Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus, MD 21227 of enter the mode of dying, such as cardiac or respiratory arrest, Approxim 23a. Part1. Enter the disease, or complications that cause I h shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Ceuse (Final disease or condition rasulting in deeth) yn. Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last Due Part II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy completion of cause of deeth?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

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death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital

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Hygiene.

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permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 Is merked oth any Injury or other traumatic event

Director

Funeral

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Completed

Be

Physician/Medical Examiner physician and sthe bunel-trans þ Completed Be 70 Certification:

98 ettending for use es signed t

1 Yes

29a. Certifier

onel 29b. Signature

edical

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> State Registrar

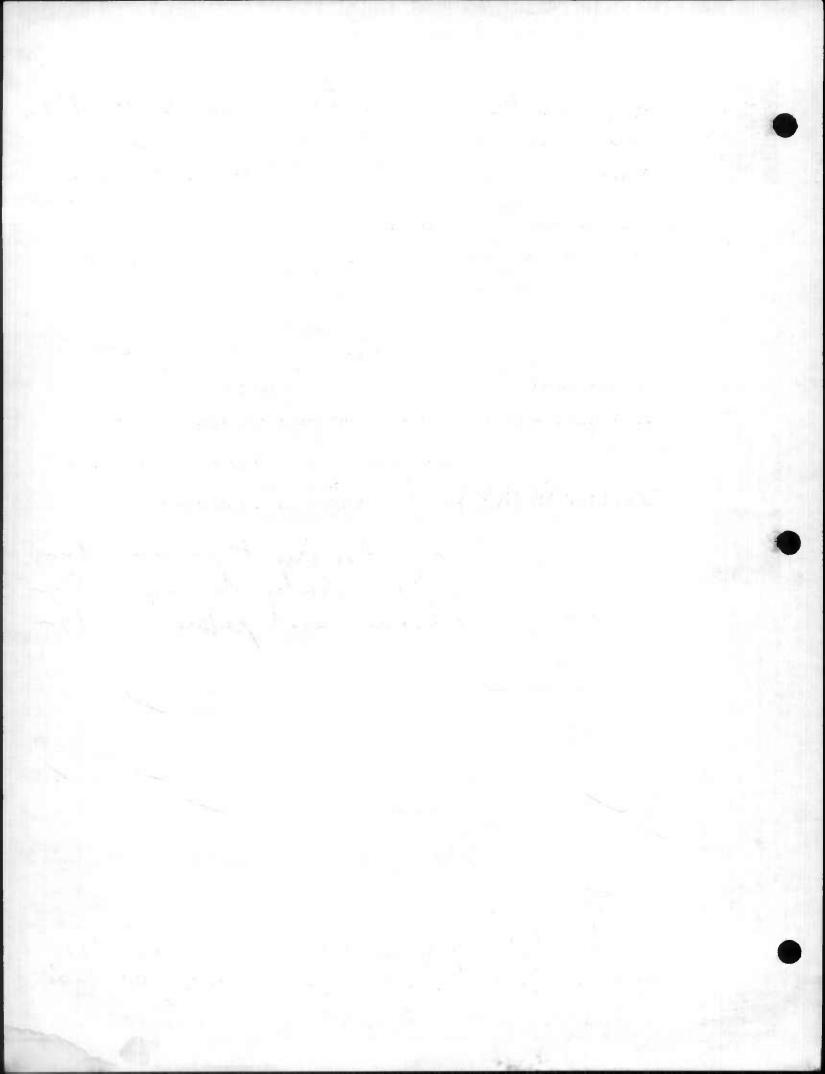
1 Yes 204 2 No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Assidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Deeth Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 10 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the cause(s) end manner es steted.

Leading Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated.

Leading Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner stated. (Check only and title of 29c. License number 29d. Date signed (Month, Day, Yeer) (Item 28a) (Type, Print) 30. Neme address of person who completed cause of death

marce Vbuera 40 31. Dete filed (Month, Day, Yeer)

Registrar's Signeture



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that the death certificate be axecuted

P.O. Box 68760,

Records,

Division of Vital

the Hospital or Attending Physician:

hours aftar

Maryland

Baltimore,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Michael Robert Coyne, Sr. October 1999 1:45 PM /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Stella Maris Hospice Timonium Baltimore 8. Deta of Birth (Month, Day, Year) 9. Birthplaca (Stata or rore Country) June 23, 1919 West Virginia If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days 1**X**0 M 2□ F 295-07-3370 Yrs. Director 80 Usuai Rasidence of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yas 2 No Director Maryland Baltimore 10e. Street and Numbar 10f. Zip Code 10g. Citizan of What Country? ŏ 1518 Chivalry Court or items 23a 21237 U.S.A. Funeral 12. Was Decedant Evar In U,S. Armed Forces? 1 20 Yes 2 □ No If Yas, Giva Yaer or Datas: WW 7 7 Rece - Amaricen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxicen, Puarto Rican, atc.) 1 Navar Marriad 2 Married 1 ☐ Yas 2 No Specify: White þ Specify: 3 X Widowed 4 ☐ Divorced "natural". Completed 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant'a Education (Specify only highast grada completed) 16b. Kind of Business/Industry Self-Employed Heating Eiamantary/Secondary (0-12) marked other than Collega (1-4or 5+) Owner & Air Conditioning Co. 12th Grade 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be permit. Peges 1 and 2 should be Departmant of Haalth end Mental Important: If Item 27 is marked of any Injury or other traumatic ev Robert M. Coune Ellen King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Michael Robert Coyne, Jr. (son) 3 Eyre Ct., Baltimore, MD 21236 20b. Placa of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Buriai 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) Dulaney Valley Mem'l Gard 10/14/99 Timonium, MD 21. Signature of Funeral Sarvice Licensae 22. Nama and Addrass of Fecility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 23a. Pert1. Entar tha disaase, or complications that ceused the daath. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one ceuse on aach lina. Approximata Intarval Betwe Onset and Death Physician fmmediate Ceuse (Finel diseasa or condition resulting in daath) /Medical a. LUNG CANCER Examiner Dua to (or as a consequence of) Sequantially list conditions, if any, laading to immedieta causa. Entar Undarlying Cause (Diseasa or Injury that initiated avants rasulting in death) Last and bunal-tran Dua to (or as a consaquanca of): attanding physiclan Physician/Medical the Dua to (or as a consaquance of) Part fl. Other algnificent conditions contributing to death but not rasulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Ž 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown signed b Completed by 24b. Wara autopsy findings evailabla prior to complation of cause of death? 24a. Was an autopsy performad? paga 2 s 1 ☐ Yas 2 No 1 Yas 2 No certificate Be 25. Was case rafarred to madical 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 6 NOther (Specify) HOSPICE Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpetiant 3 ☐ DOA 2 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 28c. Injury at Work? 27. Mannar of Death Certification: 28b. Tima of 28d. Dascribe how Injury occurred After 5 Pending invastigation 1 X Netural s aftar death.

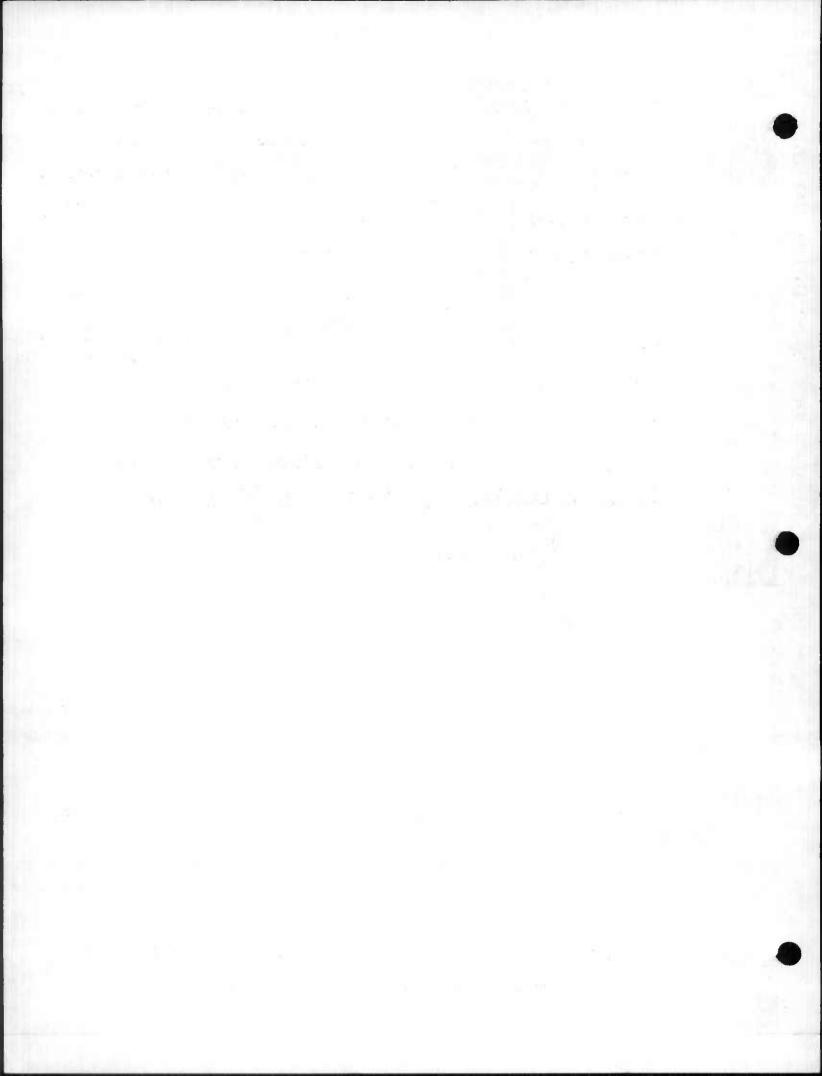
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of in by tha fur 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homlcide To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Phyaician: To tha bast of my knowladga, daath occurred at the time, data and placa, and dua to tha cause(s) end mennar es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, dete and place, and dua to the cause(s) and mannar stated. 29a. Cartifiar (Check only one) 29b. Signeture and title of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) D43725 10/12/99

State Registrar 30. Nema and address of person who completed causa of death (Item 23e) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DR. TARIQ MAHMOOD



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 9, 1999 Physician James Roy Cronshaw 11:11 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth Nursing Center Baltimore N/A If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) M 2□ F Days Months 91 212-12-3473 Director FEB 18, 1908 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location r than "natural", or frame 23s or 28s-f show the Medical Examinar must be notified at 10d. Inside City Limits MD N/A Baltimore 1 XYes 2 No Director 10e. Street and Number 3320 Benson Avenue 10f. Zip Code 21227 10g. Citizen of Whel Country? USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: 14. Race - American Indian, Black, White, etc. 11, Merital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry permit. Pages 1 and 2 should be flied within 7 Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "n eny injury or other traumatic avent, the Medians Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Henry Cronshaw Rosa Morris 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth Ann Hjelmervik/daughter 18902 Gunpowder Rd. Hampstead, MD 21074 20b. Plece of Disposition (Name of cernetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Ridge Mem. Park 10/12/99 Baltimore, MD 22. Name end Address of Fecility
MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Lice Edward A. Edward A. Gregorchik 301 Frederick Rd. Balti

23a. Part. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 301 Frederick Rd. Baltimore, MD 21228 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Cerebourscular Examiner Completed by Physician/Medical Examiner NSUFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ATHEROSCLE ROSIS that initiated events resulting in death) Last Box P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contributa to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown TROKES WITH REGHT Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? ORDNARY HEART disease 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this carificately filled in by the funeral director, t 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Tot Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 X No 27. Manner of Death 28c. Injury at Work? Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 16200 to completed cause of death (Item 23a) (Type, Print) 30. Name and address of p hoice La Carons ville, zizze

DHMH 16 Rev 6/95

Registrar

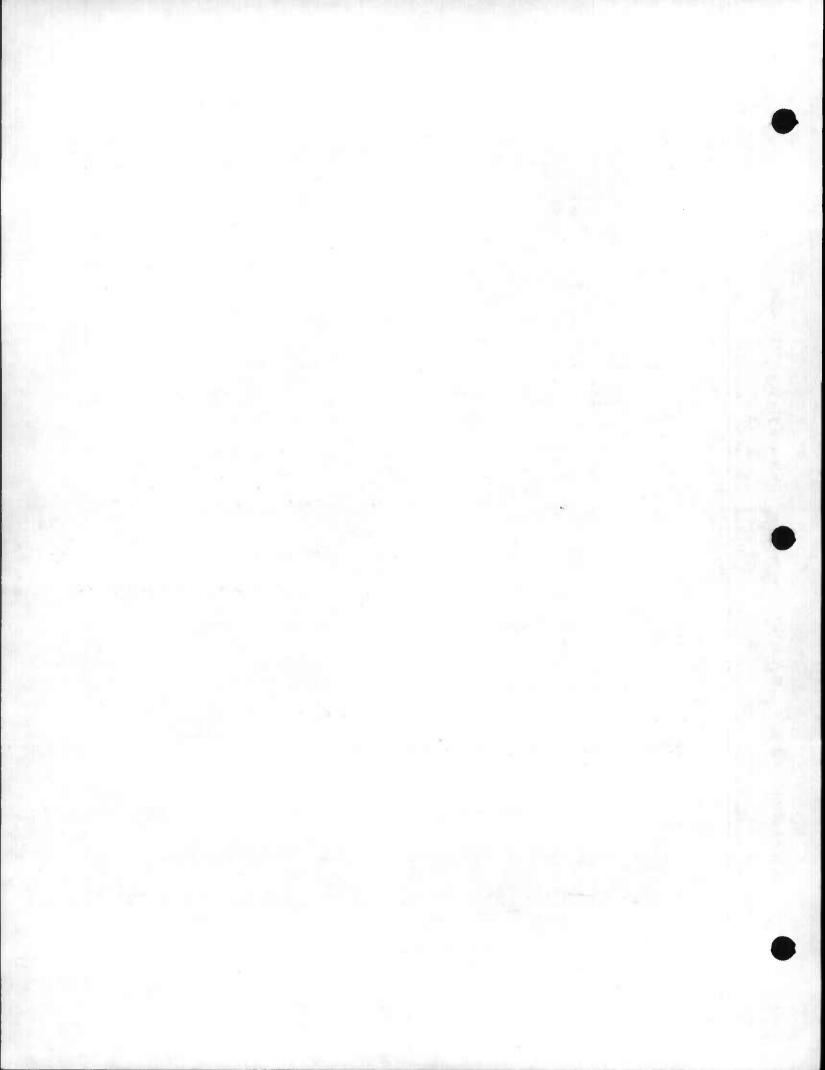
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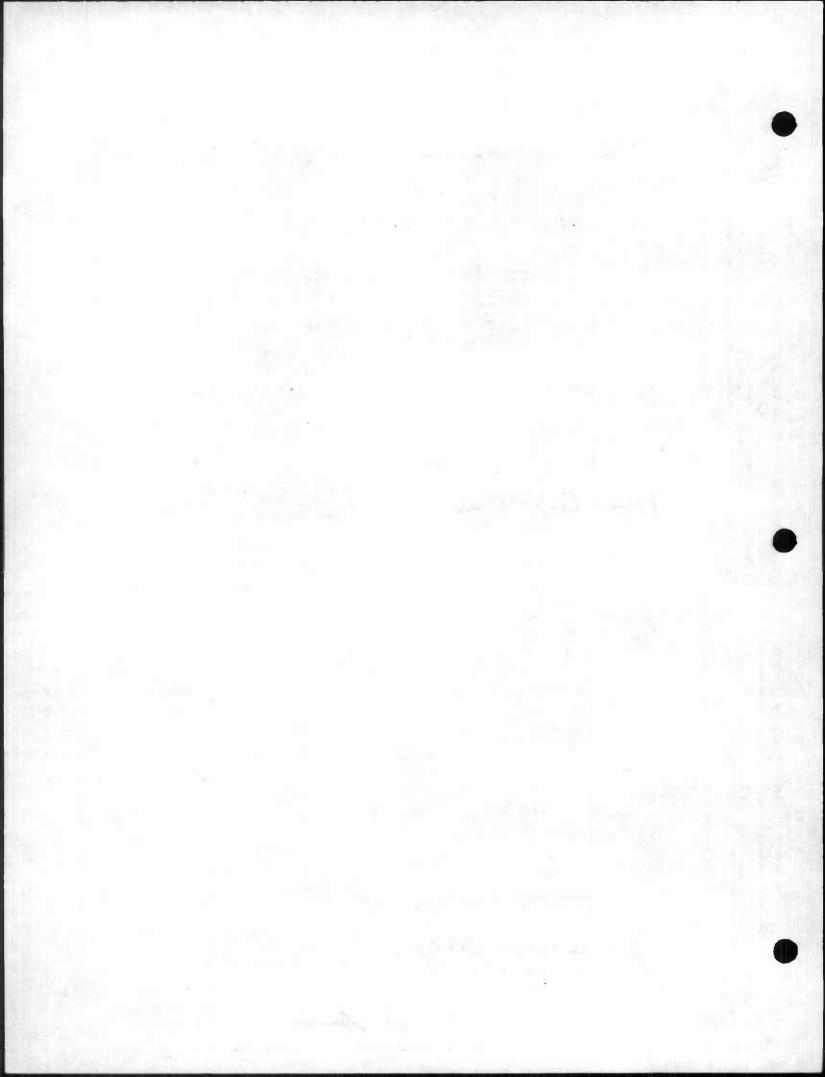
31. Date filed (Month, Day, Year)

220-C MAIDEN

32. Registrer's Signature



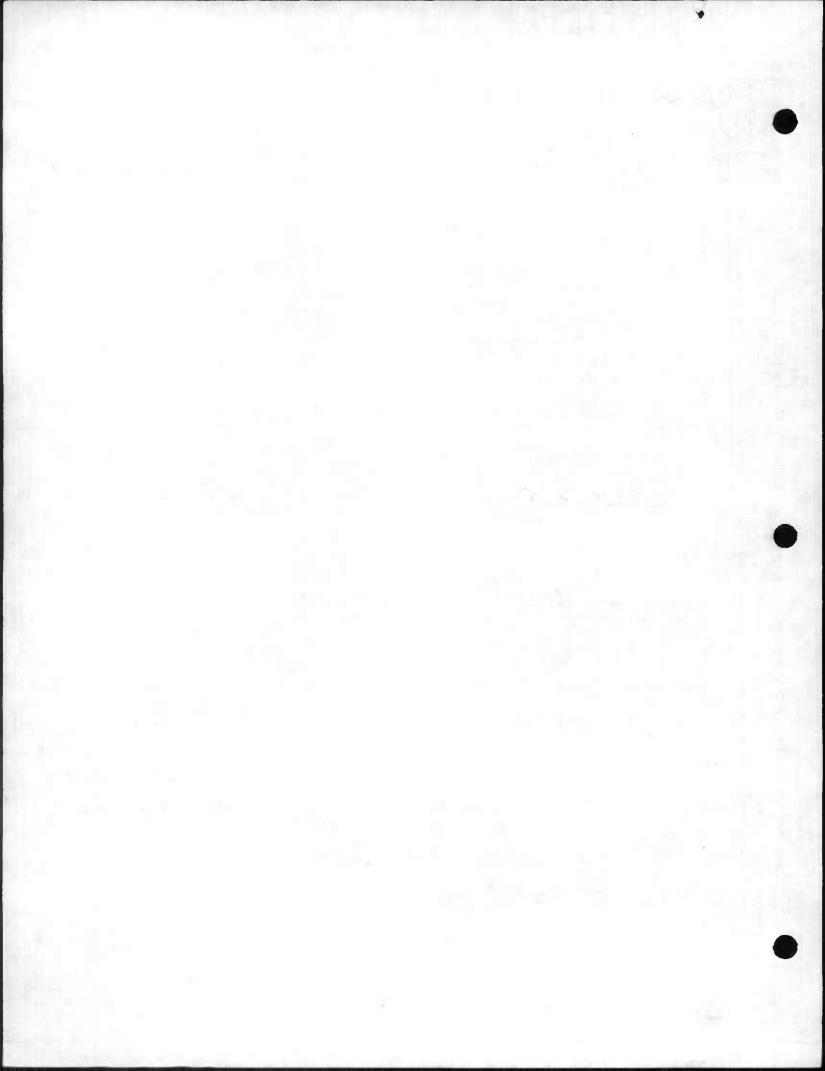
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4a Facility Nama (If not institution		LINS					OCTOR		999	1534 PM.		
	, give street and nu	mber)				b. City, Town,	or Location of De	eath 4c. Count	y of Death			
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5. Social Security Number	6. Sex 1X M 2 ☐ F	14-0-40	. last birthday) Yrs.	If Under Months	Days	If Under 24 Hours	Ain. (Month,	Birth Day, Year)	Count			
212-08-3275 Usual Rasidence of Decedant		32					JULY	11, 1967	MARY	YLAND		
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MARYLAND N	/A		BALT	IMORE						1X Yas 2 No		
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The state of the s	Armed Fo	orces?	U,S. 13. V	Vas Deced Yes, spec	lent of Hi lify Cuba	ispanic Origin n, Mexican, P	? (Specify Yes or uerto Rican, atc.)	No- 14. Ha Bla				
3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	V8	1	☐ Yes 2	2 XI No	Specify:		Speci	y: WH	ITE		
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disease or condition rasulting in death)	a	Due to (or as a conseq	uence of):	OIXC	CATION						
cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last	c	Due to (or as a consequ	uence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause				
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axaminar? 1)XXYas 2□ No	Hospital:	Inpatient 2	ER/Outpatien	t XX DO	A Oth	er:			her (Specify)		
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2 Accident invastig	ation 10-			WN I	10							
3 Suicida 4 Homicide 4 Homicide 4 Homicide 4 Sea. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) UNKNOWN							28f. Location (Street and Number or Rural Ro. City or Town, State) UNKNOWN					
(Check only 20 Medical E	xaminer: On the b	asis of axamin										
29b. Signatuse and title Obsertifier	A arki man	nor stated.	0	29c.	License	number		29d. Date aign	ed (Month, L	Day, Year)		
DL Pui	lann	- M	-()-		OCT.	E		OCTOBER	10, 1	1999		
30. Name and address of person v	1)			-	not	Dal+i	mores Ma	and 2	1201			
	MARYLAND Note that a state of the provided resulting in death) Note that conditions are sufficient conditions. The provided resulting in death) Note that conditions are sufficient conditions. The provided resulting in death) Note that conditions are sufficient conditions. The provided resulting in death) Note that conditions are sufficient conditions. The provided resulting in death are sufficient conditions. The provided resulting in the provided resulting in the provided resulting in the provided res	10e. Street and Number 10e. Street and Number 5116 WRIGHT AVENUE 11. Marital Status 1	10a. Stata 10b. County 10c. County MARYLAND N/A 10c. Street and Number 10b. Street and Number 11b. Marital Status 12. Was Decedent Ever in Armed Forces? 1 Mere Armed	10a. State 10b. County N/A BALT 10a. Street and Number 5116 WRIGHT AVENUE 11. Marital Status 1 Never Married 20 Married 3 Midowad 4 Mospital: Due to (or as a consequent large large of persulting in death) Lasi 1 Never Married 20 Married 1 Nest 1	10b. County	10b. County 10c. City, Town or Location MARYLAND N/A BALTIMORE 10t. Zip Code 10t	10e. Steats 10b. County MARYLAND N/A BALTIMORE 10c. Zip Code 11. Martial Status	10s. Statis 10s. County 10s. Celly, Town or Location NAMYLAND N/A BALTIMORE 10s. Street and Number 10s. Street Street 10s. Street Str	100. County 100. County 100. Cety, Town or Location 100. Street and Number 100. Street and Number 100. Zep Code 10. Clay Town or Location 15. Mark Number 10. Clay Town or Location 15. Street and Number 10. Clay Cap Code 10. Clay Cap Cap Code 10. Clay Cap Cap Cap Cap Cap Cap Cap Cap Cap Cap			



Certificate of Death Reg. No. 1, Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** Antoinette Catalano October 5, 1999 10:10am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 7756 Moon Fall Court Pasadena, MD Anne-Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) May 27, 1934 BrockLyn, 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 35 F 130-26-4999 65 Yrs. Director Usual Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow NY Kings Brooklyn XXX Yes 2 No Director 280-1 must be notifie 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? United States 62 Avenue V 11223 Funeral thems: 11 Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after sent of Health and Mental Hygiene.
Int! If Hern 27 is marked other than "natural", or its 1 ☐ Yes 2 2 X No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 21215-0020 White 1 Yes 20 No Specify: Specify: ğ 3℃Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 0 Stylist Hair Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumeme) Be Lella Vincent Frisone Lucy 19a. Informant's Neme/Reletionship (Type, Print)
Denise Bakhsh / Daughter 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
7756 Moon Fall Court, Pasadena Maryland 21122 or other train 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion Removel from Stete Department of Important: If any Injury or Saint Johns Cloister Cem. October 9, 1999 Middle Village, NY 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Neme end Address of Fecility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Concer metastatic /Medical Immediete Cause (Final > 2 y Cors disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue Due to (or es e consequence of) Box 68760 Physician/Medical the Due to (or as a consequence of): USB BS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy tindings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? hes certificate 1 ☐ Yes 200 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth.

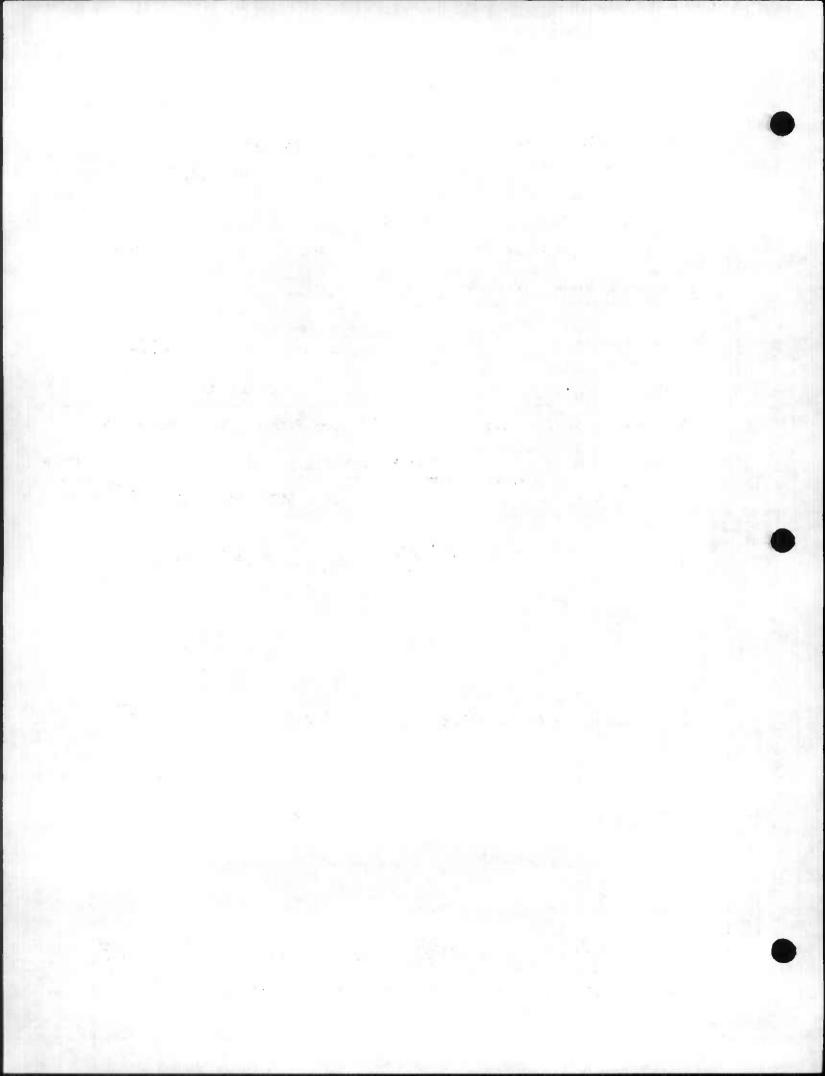
To the Funeral Director: After this carlifici completely filled in by the funeral director. 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) Daughters edical Certification: To 1 ☐ Yes XX No 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Netural
2 Accident 5 Pending 1 TYes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner steted. 29e. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60 027938 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) quahart Road Glea Burnie, 000 21061 795 A 500 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

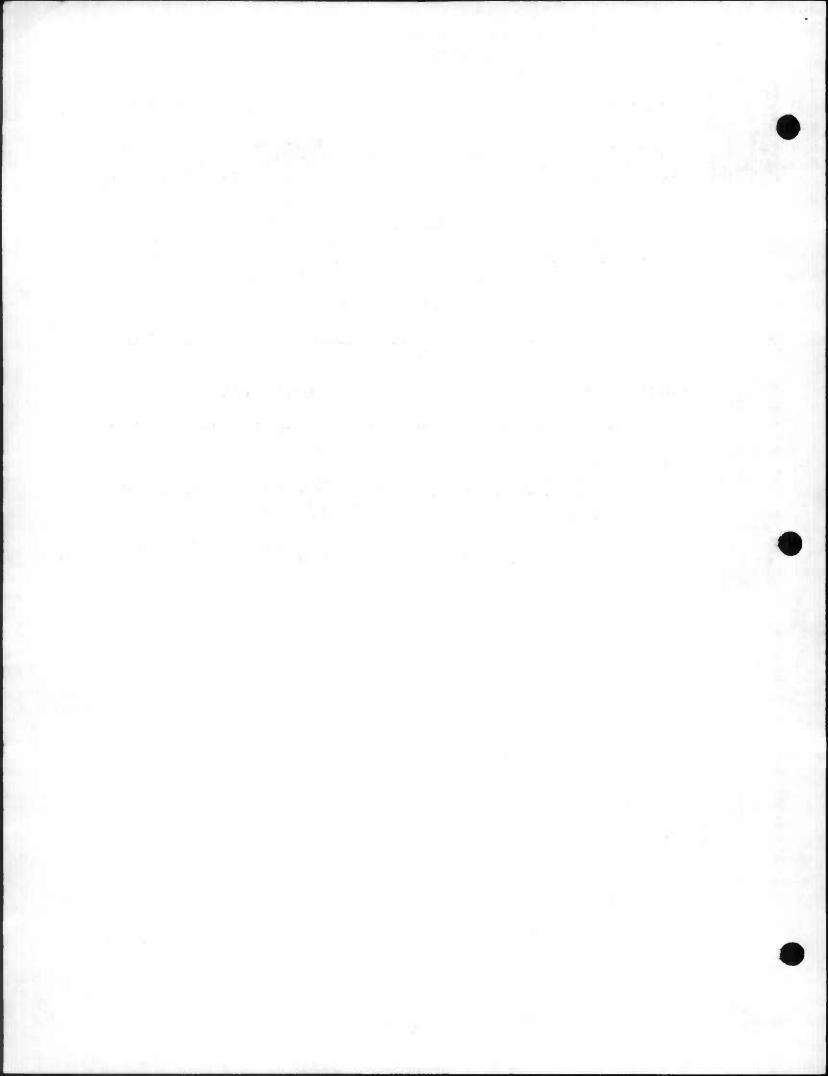
		Department of Health and Mo	00 01000
Dhoodalan	Decedent's Nama (First, Middle, Last)		2. Data of Death Month Day Yaar 3. Time of Death
Physician /Medical Examiner	James Washington Crook, Sr. 4e Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	October 12, 1999 5:05 a.m.
	Good Samaritan Nursing Home	Baltimo	ore N/A
Funeral Director	5. Social Security Number 216-16-0802 Usual Residence of Decedent 6. Sex 112 M 2 F 7. Age (In yrs. last be	Yrs. Hunder 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Data of Birth (Month, Day, Year) July 23, 1920 9. Birthplace (State or Foraign Country) Maryland
rer death with the Maryland Herre 23s or 28s-f show Instrust be notified at Unnered Director	10a. Stata 10b. County 10c. City, Tow	wn or Location Itimore	10d. Inside City Limits 1 ⅓ Yes 2 □ No
or 28s-f of be notified	10e. Street and Number	101. Zip Code	10g. Citizen of What Country?
e 23e mari	6005 Eastern Parkway	21206	United States
		13. Was Decedent of Hispanic Origin? (Spetif Yas, specify Cuban, Mexican, Puarto F	14. Race - American Indien, Black, White, atc. Specify: White
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mertal Hyglene. T is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 +	a. Decedent's Usual Occupation (Giva kind of work dona during most of workin lifa. DO NOT use retired) Pharmacist	federal Government
Viand 2 Vietral Hygi Mental Hygi Mental Hygi Mere other rite event, 1	17. Father's Nama (First, Middle, Last) Charles Samuel Crook		(First, Middle, Maiden Sumama)
- 22.5	Mrs. Jane E. Crook / wife	b. Mailing Addrass (Street and Number or Rural 6005 Eastern Parkway	Baltimore, MD 21206
Baltimore semit. Pages 1. Separiment of Ha mportant: If then my injury or oth	1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata	of Disposition (Nama of ary, cremetory or other place)	Data 20c. Location - City or Town, State
ritmer ritemit		Wood Cemetery 10	0/15/99 Baltimore, Maryland
Depart Part Bank	21. Signature of Funeral Service Licenses Michael E. Canapp	LEONARD J. RUCK.	5305 Harford Road INC. Baltimore, MD 21214
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition rasulting in death) Due to (or as a	not entar the mode of dying, such as cardiac of	Prostate Approximeta Interval Batween Onset and Deeth
/ 6U, be executed sicien and burial-transit cai Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury c.	consequence of):	
	that initiated events	consequence of):	
death cent death cent d for use	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	23b. Did tobacco use contribute to the cause of death?
Phy the detached	Chrone obstructive (^	1 Yee 2 No 3 Probably 4 Unknown
requir requir should		0	24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death?
= F # A O			1 □ Yas 2 No 1 □ Yes 2 No
/IIC	25. Was case referred to medical axaminer?	26. Place of Death	(Check only ona)
Physic this o	1		ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred
After fune	1 Natural 5 Pending (Month, Day Year)	Time of Injury M 28c. Injury at Work?	ad. Describe now injury occurred
DIVISION C be or Attending P as after death. al Director: After t led in by the funer Certification:	2 Accident 3 Suicide 6 Could not be detarmined 4 Homicide 6 Could not be detarmined 28e. Place of Injury - At home, f building, etc. (Specify)		8f. Location (Street and Number or Rural Routa Number, City or Town, Stata)
he Hospi in 24 hou he Funer pletely fill edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of axamination are and manner stated.	e, death occurred at the tima, data and place, a nd/or investigation, in my opinion, death occurre	nd due to tha cause(s) and mannar as stated. d at tha tima, data and place, and dua to tha cause(s)
To the Withing To the Common	29b. Signature and title of continue Leffrey Cooll	29c. License number Dog 346 90	29d. Data signed (Month, Day, Year) 10-12-99
10	30. Name and stress of benon who completed cause of death (Item 23s) Jeffrey Cool, M.D. 9712 Belair	MD.	21236
State Registrar	Jeffrey Cool, M.D. 9712 Belair 31. Data filed (Month, Day, Year) 32. Registrar's Signature	D. Sparks	



Please

Type or Print in Blac State of Maryland /	ck Indelible Ink. Assure Department of Health and	All Copies Mental Hyg	Are L	egible.	188	
	Certificate of Death		eg. No.		. 0 0	
t		2. Data of Dea Month October	Day	Yaer 1999	3. Tima of 12:30	
e streat end number)	4b, City, Town, o	r Location of Deeth	40.0	ounty of Death		

Physic	ian	Decedant's Nama (First, Middla, III)								2. Data of De Month	Dav	Yaer	3. Tima of Death
/Medi		Lester E. Cri								October	5	1999	12:30 am
Exami	ner	4e. Fecility Neme (If not institution, g	give streat end nur	nber)				4b. City, To	wn, or Li	ocation of Deetl	4c. Co	unty of Death	
		4401 Arabia Av				- K. II.		Balti		T			
Funeral			i. Sex 112 M 2 □ F	7. Aga (In yrs.		Months	Deys	If Undar Hours	Min.	(Month, Da	y, Year)	9. Birth	place (Stete or Foreigntry)
Director		246-09-9113 Usual Residence of Decedant	••	79	113.					July 9,	1920	Ohio	
Pund in		10a. Stata 10b. County		10c. Cl	ty, Town or	Location							10d. Insida City Limit
72 hours effer deeth with the Marylend natural, or Neme 23a or 28a-f show Jical Examiner must be nothed at	ō	MD		D - 1	1								1 Yes 2 N
28 m	Director	MD 10e. Street and Number		ва.	ltimo		p Coda				10n Citizan	of What Cou	intry?
Sa or		4401 Arabia Aven	110				1214				U.S.		,
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	era	11. Maritai Status	12. Was Dace	dant Evar in L	J.S. 1:				oln? (So	ecify Yas or No		A . Race - Amar	can Indian
r Her	Funerai	1 ☐ Nevar Married 2 ☑ Married	Armed Fo	rcas?		if Yes, spe	ecify Cub	en, Maxican	, Puarto	ecify Yas or No Rican, atc.)		Black, Whita	
o'l's	by	3 Widowad 4 Divorced	If Yas, Giv	a etes:1942-	-46	1 🗆 Yas	2√ No	Specify:			Sp	eclly: Whi	te
a while 7.2 flours eller deeth with the maryner lien. Jene 1 than "natural", or flems 23a or 28a-f show the Modical Examiner must be notified at	Completed	15. Decedant's	Education		16a. De	cedant's Usu	al Occup	pation			16b. Kind	of Bualnass/Ir	ndustry
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marked matic ev	ToE	Harold Everet Cr	ist					Stel	la M	lartha F	Rose		
5 3	-	19a. Informant's Name/Ralationship			19b. Ma	ailing Address	s (Street			al Routa Numb		own, Stata, Zi	p Coda)
tra tra		Theresa E. Crist	/spouse		440	l Arab	ia A	venue	. Ba	ltimore	. MD	21214	
Item 27 other tra		20a. Mathod of Disposition	•	20b. I	Place of Dis	sposition (Na	ma of			Data		lon - City or T	own, Stata
t: If		1 ☐ Buriai 2 ☐ Cramation 3 4 ☑ Donation 5 ☐ Othar (Spec		Stata	сетечету, с	ramatory or o	omar pra	ce)	i				
Depertment of P Important: If Ite any Injury or of once.		21. Signature of Funaral Service Lic	**			22. Nama ai	nd Addra	ss of Facilit	v				
Depe Impoi			S. Wade,	Direct	tor	State	Anat	tomy E	Soar	d, 655	W. Bal	Ltimore	St.,
		Do Dods Falsable disease				Baltin	nore	, MD	2120		cist.		
		23a. Part1. Entar tha disaase, or co shock, or heert feilura. List on	ily one ceuse on a	ach lina.	tn. Do not a	antar tha mod	da of dylr	ng, such as	cardiac	or respiretory e	rrast,	1	Approximata Interval Between Onset end Deeth
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Madical		Immediate Cauca /Final) /	1.		/	0 1	// /				7
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** 1,20 PM /Medical 4c. County of De 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner mar mor a If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Oountry) **Funeral** Days 223-32-313 Usual Residence of Decedent 1□M 20 F Yrs Director 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 28a-f show Maryland 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 234 Funeral d 12. Wes Decedent Ever in U.S. Amed Forces?

1 Yes 2 No the Yes, Give Hems Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race -Black White etc. filed within 72 hours after 1 Never Merried 2 Merried naturel, or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) d sourd perator is marked other permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If item 27 is marked oth any Injury or other treumatic event pace. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Be 20 JESSE BONNES 193. Informant's Name/Reletionship (Type, Print) (Jaug hter 6 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 2 20b. Place of Disposition (Name of 20e. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place) 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 □ Other (Specify) Son ore 21. Signature of Funerel Service Line 22. Name and Address of Facilit Joseph 2222 L ra North Ave. .21216 ter the disr. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart fellur. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final · METASTATIC OXECINOMA OF 10 MO. disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of): attending physician for use as the burie Physician/Medical the Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE signed t þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? MELLITUS DIKBETES completion of cause of death? 1 Yes 2,25 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification plately filled in by the funeral director. Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outputient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation N/A. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

State Registrar 31. Dete filed (Month, Dey, Year) OCT 1 3 1999

rugan

30, Name, and address of parson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and 186 of certifier

82 32. Registrar's Signature

Mus)

29c. License number

216349

wo.

29d. Date signed (Month, Day, Year)

10.11.99.

DHMH 16 Rev 6/95

Baitimore, Maryland 21215-0020

P.O. Box 68760,

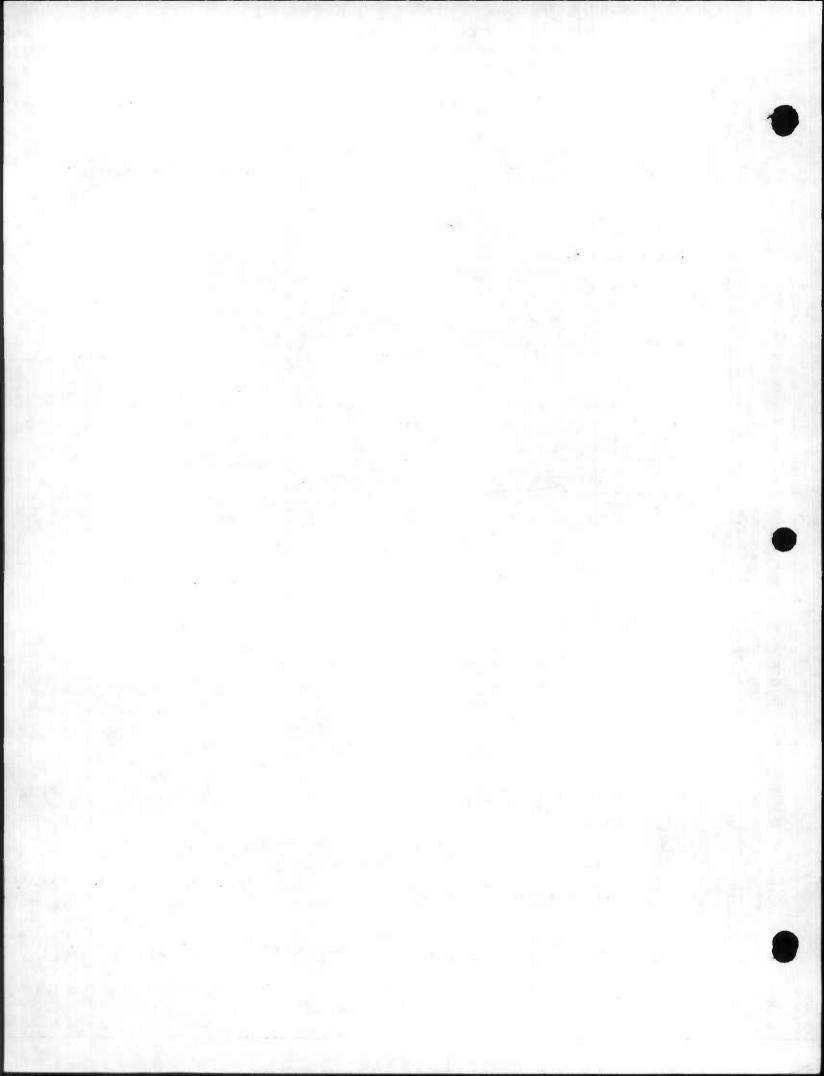
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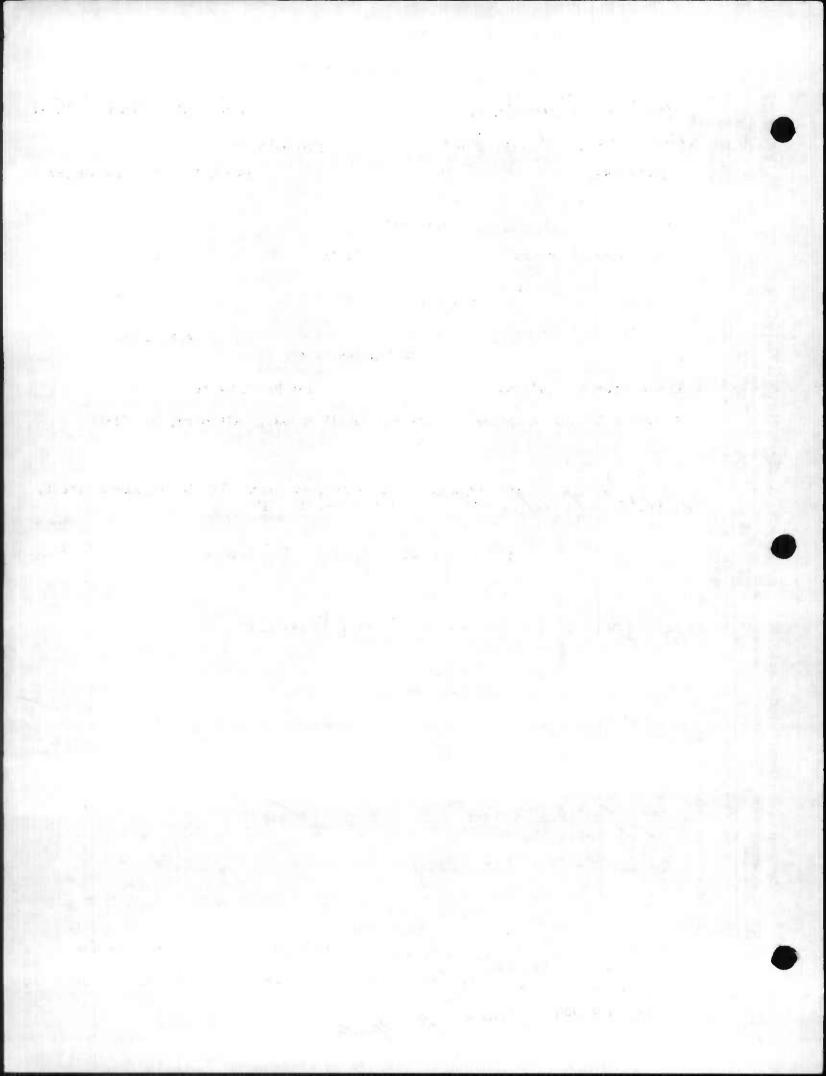
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- Physician	1. Decedent's Neme (First, Middle, Las	IVI IN A		ificate of		2. Date of Dea Month	th Dev _	3. Time of Deeth
mysician /Medical	June		n			octobe	PO 7	1999 06:40 pm
Examiner	4a Facility Name (If not institution, give	of Mary	land		Batt	r Location of Death	Ball-	timore City
uneral rector	5. Social Security Number /6. Security Number 218-26-0527	TH OME	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		, Year)	9. Birthplace (State or Foreign Country) Maryland
B 18	10a. State 10b. County	10c.	City, Town or Loca	ation				10d. Inside City Limits
tilling ctor	Maryland n/a	Ва	altimore					1 X Yes 2 □ No
be notified Director	10e. Street and Number			10f. Zip Code		1		What Country?
doer must Funeral	2440 Harriet Avenu	12. Wes Decedent Ever in	1 U,S. 13. W	21230 es Decedent of H	lispanic Origin? ((Specify Yes or No- erto Rican, etc.)	USA 14. Rad	ca - American Indian,
Exan by	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:	100	Yes, specify Cubo		erto Rican, etc.)	Specif	ck, White, etc. y: White
r, the Medical Completed	15. Decedent's Edi		(Give ki	nt's Usuel Occup	during most of w	orking	16b. Kind of B	usiness/Industry
De Me	Elementery/Secondery (0-12)	College (1-4or 5+)		O NOT use retired	d)		D -	
ent, n	12 17. Father's Neme (First, Middle, Last)	0	Secre	tary	18. Mother's N	ame (First, Middle, i		rts Supply
fic ever fic ever	Henry Kuhn				Gertrud	le McCurdy	7	
	19e. Informent's Neme/Reletionship (7)	iype, Pnint)	19b. Meiling	Address (Street		Rural Route Number		, State, Zip Code)
12 m	Linda J. Kramer /				alley Dr			Maryland 2122
1 0 10 10	20a. Method of Disposition 1 ★ Burial 2 ☐ Cremetion 3 ☐	Removel from Stete	cemetery, creme	tion (Neme of itory or other plea	•			- City or Town, State
riant riany	4 Decretion 5 Other (Specify,		leadowrid				Elkridg	ge, Maryland
amy any a	21. Serialista Girdina Service Cicente	A A				ome, Inc.		
	23a. Pert 1. Enter the disease, or comp	licetions thet caused the de						Maryland 21229
sician	shock, or heart feilure. List only of	one ceuse on each line.						Intervel Between Onset end Deeth
edical	Immediate Cause (Fine)	Sub	dura	(1+	emol	toma		1
miner	resulting in deeth)	M Dye to	(or as a conseque	nce of):	TO	toma arctil		and a
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ician and bunal-transit at Examir	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to	o (or es e conseque	ence of):		al	100 Bran	//
physician s the buris edical E	Cause (Disease or Injury that initiated events resulting in death) Lest	cDue to	(or es e conseque	ence of):		STRUTSANDE APPE	1916	16
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for use a		d					V	
ysi the	Pert II. Other eignificant conditions co	ntributing to death but not	resulting in the und	lerlying cause giv	ren in Pert I.			ontribute to the cause of death?
d be detacted by d be detacted d by Phy						_ 1 U Y	es 2 No	3 Probably 4 Unknown
shoul						24a. Was a perfor	in eutopsy med?	24b. Were eutopsy findings evailable prior to completion of cause of death?
age 2						1 U Y	es 2 No	1 ☐ Yes 2 12 No
s certificate hadinector, page director, page To Be Com	25. Was case referred to medical				26. Placa of D	aeth (Check only or	10)	
this central direction of the central directio	examiner? 1 ☑ Yes 2 ☐ No	Hospitel: 1 Inpatient 2	☐ ER/Outpatient		4 LI Nursing	Home 5 Resid	ence 6 □Ott	ner (Specify)
e Le	27. Menner of Death 1 □ Neturel 5 □ Pending	28a. Dete of Injury (Month, Day Your	28b. Time of Injury	28c. Injur Wor		28d. Describe h	-	
al Director: After t led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be	OCTOBER 1	199 6:40r		Yes 2 No	. 0000	own S	ber or Rurel Route Number,
§ 5 =	4 ☐ Homicide determined	28e. Plece of Injury - A building, etc. (Spe	city)	it, rectory, office		City or Town	n, Stete)	rue, Baltimore, M
		sician: To the best of my k				ce, and due to the c	ause(s) and m	enner es stated.
y filled in	(Check only 2 Medical Exam)	iner: On the basis of exam and menner steted.	inetion end/or inve	stigation, in my o	pinion, death oc			
the Funeral Dir pletely filled in edical Ceri	one) 2 Medical Exami			29c. Licens	e number	2	9d. Date sione	A different Dr. Maria
To the Funeral Director: A completely filled in by the funeral Medical Certificati		11						ed (Month, Day, Year)
To the Funeral Dir completely filled in Medical Cert	one)	Kole i	0.0					
To the Funeral Dir completely filled in Medical Ceri	one)	propleted cause of death (I	tem 23a) (Type, Pr					-9 1999 -Baltimera ma



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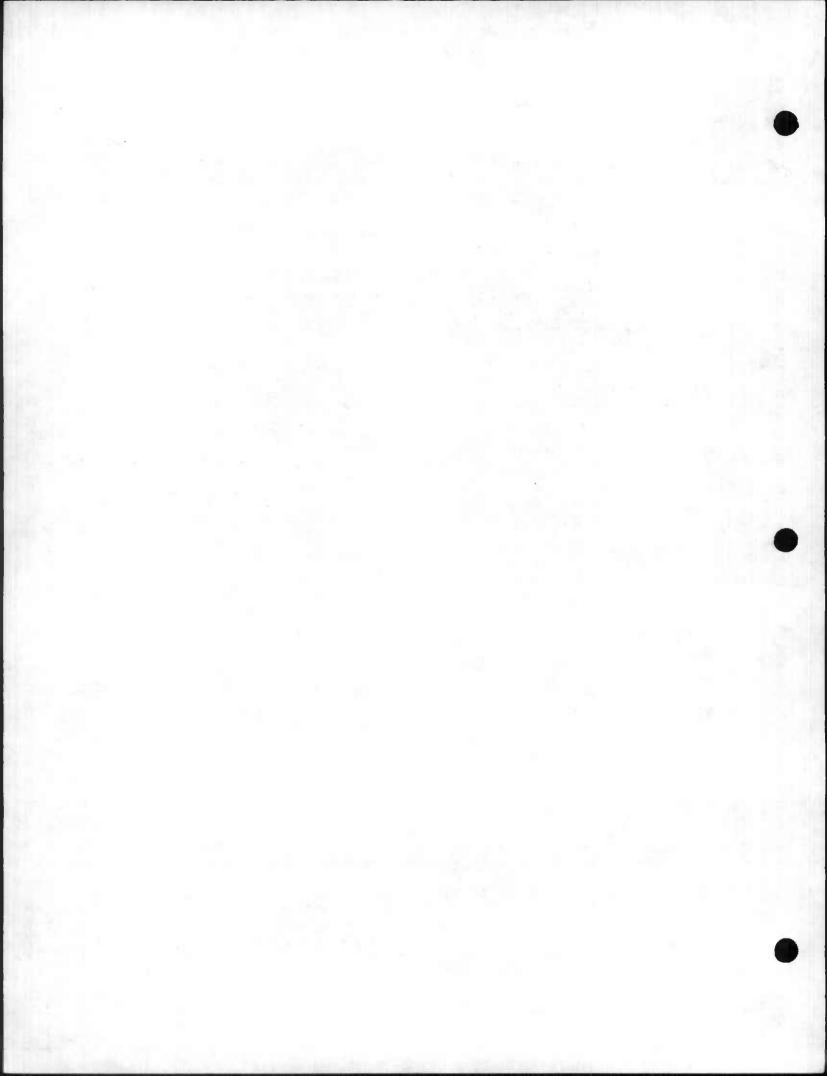
			,	Certificate	of Death		Reg. No.	31004
		Decedant's Nama (First, Middla, Last)				2. Data of De		3. Tima of Death
Phys /Mo	ician dical	Melvin DONALDSON				09-	30-19	99 8:15 A
Exan		4a Facility Nama (If not institution, give street and number)			4b. City, Town, or	Location of Deat	h 4c. County o	f Death
A		MANOR CARE - HOLAND TA	mh		Pattimo			
Funer Directo	_	5. Social Sacurity Number 217-09-1545 Usual Rasidance of Dacedant	(In yrs. last bin	Yrs. If Undar 1 Months [Yaar If Undar 24 Hrs. Days Hours Min.	8. Data of Bi (Month, De March	th ay, Year) 1, 1915	9. Birthplaca (Stata or Foraign Country) New Jersey
D M			10c. City, Town	n or Location				10d. Insida City Limits
heath with the Maryler ne 23s or 28s-f show must be notified at	Į,	MD	Balti	more				n Yas 2 No
the noth	Director	10e. Street and Number	Darer	10f. Zip Co	oda		10g. Citizen of W	hat Country?
3a o		3976 Edgehill Avenue		212	211		U.S.A.	
her d	by Funeral	11. Marital Status 1 Navar Marriad 2 Married 3 Widowad 4 Divorced 12. Was Decedant Every Armed Forcas? 13. Was 2 Navar Marriad 2 Married In Yas 2 Navar Marriad 2 Navar Or Detes: 10.			nt of Hispanic Orlgln? (S r Cuban, Maxican, Puan No Specify:	pecify Yas or No to Rican, atc.)	14. Raca Black Specify:	- Amarican Indian, c, Whita, atc. Whate
21215-0020 d within 72 hours at giene. ir than "natural", or the Medical Exam	Completed	15. Decedant's Education (Spacify only highast grada complated)	16a.	Decedant's Usual C	Occupation dona during most of wor	rkina	16b. Kind of Bus	inass/Industry
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STORE D	Be	17. Fathar's Nama (First, Middla, Last)					, Maiden Sumama	0
Merid Merid	2	Thomas Graham Donaldson				rl Wylie		
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumetic event		19a. Informant's Name/Ralationship (Type, Print) Elizabeth Donaldson/spouse			Street and Number or Ru			21211
- 5005		20e. Mathod of Disposition		f Disposition (Nama	ill Avenue,	Date		City or Town, Stata
Baltimore wmil. Pages 1: Separtment of He mportant: If Nem my Injury or oth		1 ☐ Bunal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☑ Donation 5 ☐ Other (Specify)		ry, cramatory or othe	ar placa)	Data	200. Location	ny or rown, state
Ball Departiment	9000	21. Signature of Fundral Service Licensee Ronald S. Wade Div	rector	State A	Addrass of Facility natomy Boar re, MD 212		W. Balti	more Street,
Physicia	n	23a. Purt1. Entar tha disaasa, or complications that causad the shock, or haart failura. List only ona causa on each line	ha daath. Do r	not antar tha moda o	of dying, such as cardia	c or raspiratory	arrest,	Approximete Intarval Batween Onsat and Death
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Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical C	29e. Cartifiar (Check only one) 12 Certifying Physician: To tha best of a gard mannar state	xamination en	a, daath occurred at ad/or invastigation, in	the tima, data and place my opinion, daath occu	a, and due to the urred at tha tima	causa(s) and mar , data and placa, a	nner as stated. ind dua to tha cause(s)
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		Michael A Randolph MD		33 N. CA	LVERTST	#USS	Balha	VI MD 2/218
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State of Maryland / Department of Health and Mental Hygiene 9 3 | 885

## Helen Fulton Sowash Fels ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year armer and number) ## General Name (Prince Matthews, year) ## General N				Certi	ificate of	Death		Reg	. No.	0 1	000
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Schimurek Funeral Home, Inc. 9705 Belain Rd., Baltimore, MD 21236 23a. Part Enter the eleves. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate above, or hard feature. List only one cause or each inc. Immediate Cause (Final disease or condition resulting in death) Belain and the second of		4 □ Donation 5 □ Other (Specify)	ale	Mour	rt Crem	atory		14/99	Baltimo,	re, 1	Marylan
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2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At homa, farm, street, factory, office 28f. Location (Street end Number or Rural Route Number of City or Town, Stata) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Name and address of person who completed cause of death (Item 23a) (Type	-	I Tes 212 No I I I In			3LI DUA	4 LI NUI				(Specify)	
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Attending Physician: After this

Certification: To

death. within 24 hours after death To the Funeral Director: completely filled in by the ŏ Hospital edical the

XI

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DHMH 16 Rev 6/95

State Registrar

address of person who completed cause of death (Item 23a) (Type, Print)

199

TreeT

investigation

6 Could not be determined

2 Accident

3 Sulcida

29a. Cartifier (Check only one)

30. Name

4 C Homicide

29b. Signatura and title of certifier

1305

laylor

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number O.C.M.E

Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and mannar stated.

and

1 Certifying Physician: To the best of myknowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

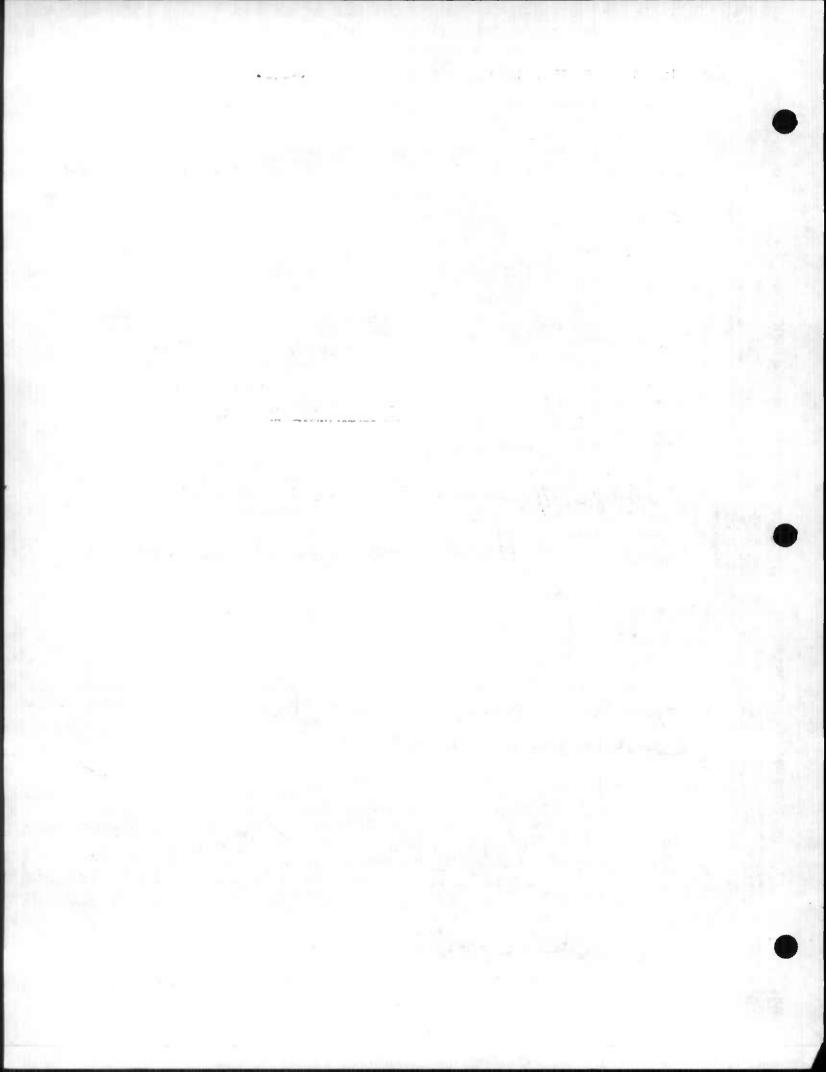
29d. Date signed (Month, Day, Year)

Baltimore

OCT. 12, 1999

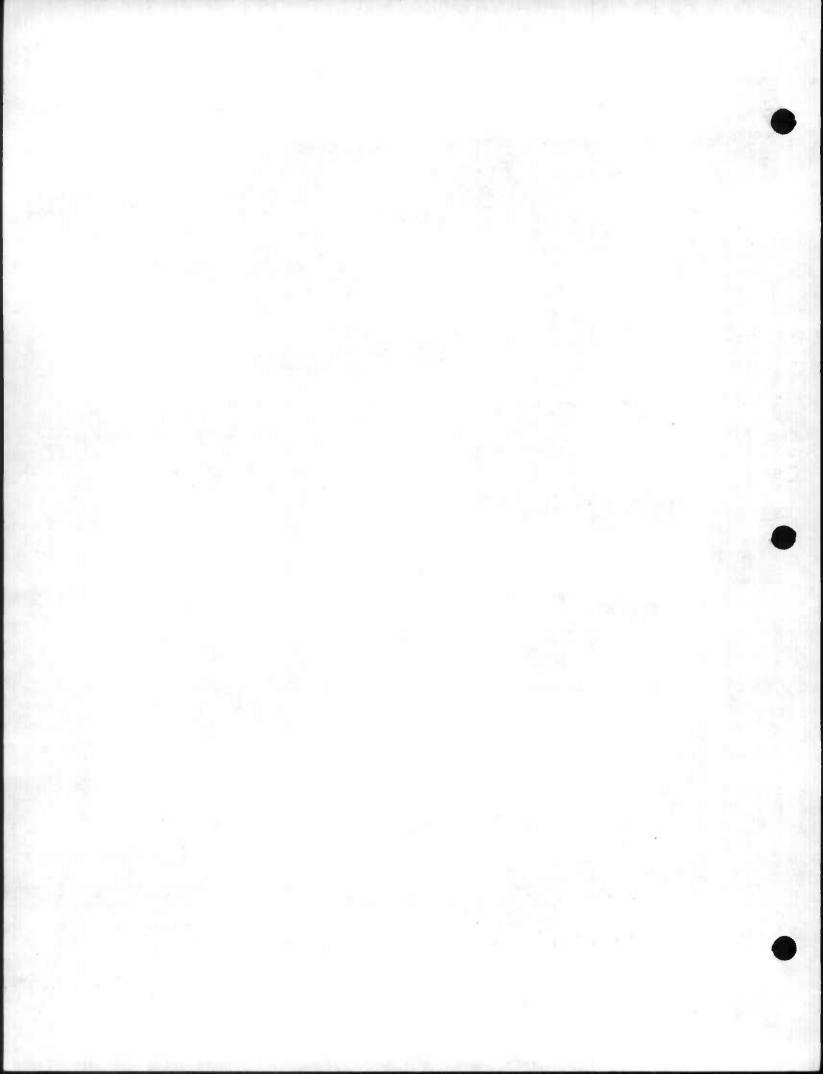
estune 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

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					,		partment of ertificate of			Reg. No.	0		1007	
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Examine	r	le Facility Neme	(If not institution, give	street and number) ()	0		4b. City, Town,	, or Location of De	ath 4c.	County of	f Death		
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Funeral Director		5. Social Security 246–16	5-2198	ex 7.7	Rge (In yrs. 8:		Months Day			Birth Day, Year) 24,1	916	9. Birthpl Count MD	aca (State or Foreign try)	
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000	Dy rur		rried 2 Merried 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Yeer or Detes	s? 1No X	S. I	3. Wes Decedent of If Yes, specify C	uban, Mexican, P	? (Specify Yes or uerto Rican, etc.)		t 4. Race - Black, Specify:	, White, e	elc.	
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_ 5 00		examiner?	₹No	Hospitet:	tient 2	ER/Outpa	tient 3 DOA	Other	ng Home 5□R		6 Other	(Specify	")	
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To the Hospital or within 24 hours aft within 24 hours aft completely filled in		29e. Certifier (Check only one)	†☆ Certifying Phy 2☐ Medical Exam	relcian: To the bes iner: On the basis and menner:	of examinet	wledge, de tion and/or	eth occurred at the investigation, in m	time, date and p y opinion, death o	lace, and due to to occurred at the time	ne cause(s) e, date end	and man	ner as stand due to	ated. the cause(s)	
To the comp		Signatura-en	d the of certifier	Hogar	th		29c. Lice	ense number		29d. Det	e signed	(Month, L	Day, Year)	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last, Time of Deeth Month al own ennon DM 4b, City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, giva street end numbar) Bult war Suma If Undar 1 Yaer If Under 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 6 Sax Birthpieca (State or Foreign Country) Months Deys 1 M 2□ F Hours 81 July 29, 1918 Illinois 265-16-2843 Usuel Rasidence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yea &☐ No Baltimore Baltiamore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 3901 Hannon Court 21236 12. Was Decedent Evar in U,S. Armed Forces? ↓□ Yes 2□ No If Yes, Give Yeer or Detes: W.W. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes .2 ☐ No Specify: Specify: White 3. □ Widowad 4 □ Divorced II16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Federal Government Elementary/Secondary (0-12) Civil Engineer 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) James Lennon Foley, Sr. Frances Irene Dolan 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) 19a, Informent's Name/Reletionship (Type, Print) James L. Foley, III/son 17 Hinesleigh Court, Baltimore, MD 20b. Pieca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stata 4 Donetion 5 □ Other (Specify) 21. Signature of Furgerel Servica Licansee 22. Name end Address of Fecility Ronald S. Wade Director State Anatomy Board, 655 W. Pert1. Enter the disease for complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, incok, or heart feiture. Eist only one cause on each line. State Anatomy Board, 655 W. Baltimore Street Approximete Intervel Between Onset end Death 20 days Phrumonia Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Disease ears an 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably € Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes No 25. Was casa referred to medical 26. Place of Deeth (Check only one) axeminer? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Yaar) Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No 2 ☐ Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Streaf and Number or Rural Routa Number, City or Town, Stete) 4 Homicide

The law requires that the death certificate be asscuted pue physician e the buriel Box 68760 P.O. ed by the detached ed by Division of Vital Records. has page certificate Phospital or Attending Physician; 24 hours after death. Puneral Director: After this certifica funeral director, filled in by

Physician

/Medical

Examiner

Director MD

Funeral

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Completed

Funeral

Director

itam 27 is marked other than "naturel", or itama 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 'Department of Health and Mentel bygiane. Important: If item 27 is marked other than "reny Injury or other traumetic event, me Med

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

the Marylend

72 hours efter death

Maryland 21215-0020

Baltimore,

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28e. Pleca of Injury - At home, ferm, straet, fectory, office building, etc. (Specify)

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner steted.

29b. Signatificand title of certifie

29c. License number

Hospita

29d. Date signed (Month, Dey, Year)

Loch Raven Block

Bultimore, MO 21239

5601

no completed cause of death (Item 23e) (Type, Print) 30 Name and address of person

Good HULHTON VID MD

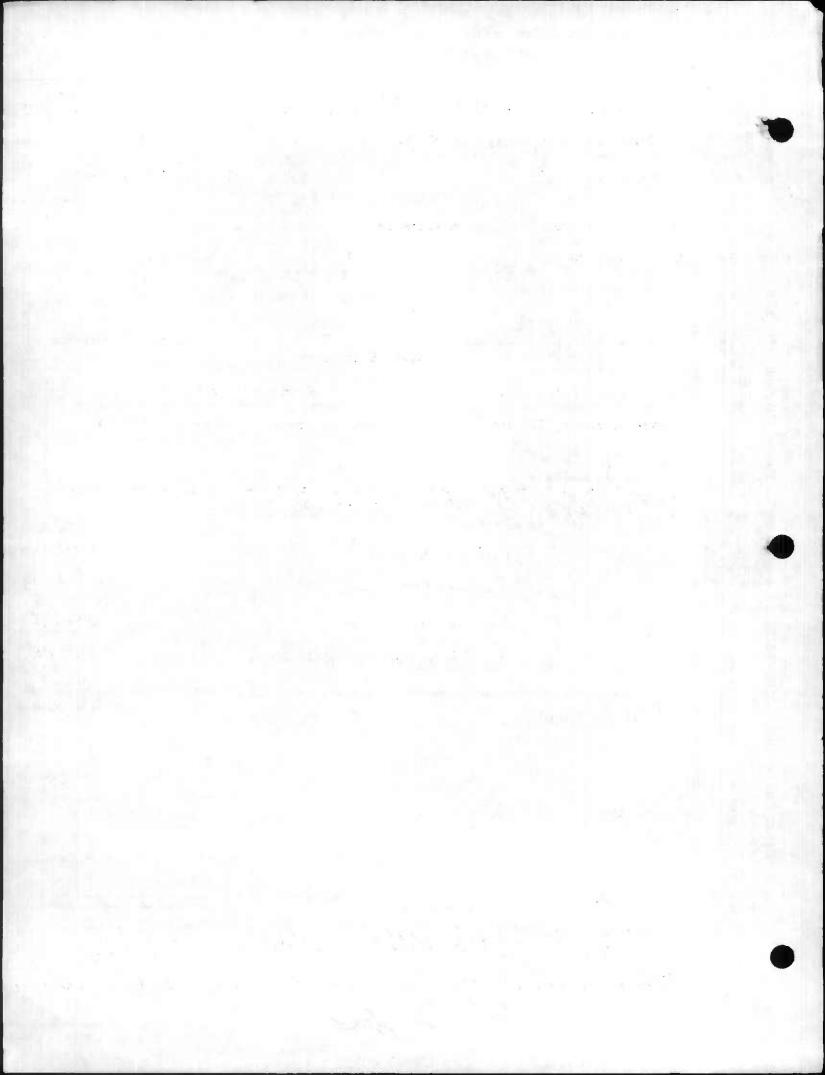
31. Dete filed (Month, Day, Year)

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Registrar's Signeture

State Registrar

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent'e Neme (First, Middle, Last) 45 **Physician** /Medical 4b. City, Town, or Location of Deeth 4c. County of Di Feellity Neme (If not institution, give street and number) Examiner MOre MILVA 12 5. Sociel Security Number II Linder 1 Yeer 6. Sex 7. Age (In yes, last birthday) 13-26-7916 Deys Hours 1□ M 200 F **Director** Usuel Residence of Decedent 10e. State 10b. County 10d. Inside City Limits Itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Directo Vary and imor 10g. Citizen of Whet Country? 10f. Zip Code 260 50n Funerai d 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Race - American Indien Bleck, White, etc. 11. Marital Stetus 1 ☐ Yes 2 🕱 No If Yes, Give Yeer or Dates: 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry snould be filed within the and Mentel Hygiene. Is marked other Elementery/Secondary (0-12) College (1-4or 5+) urses 0 17. Father's Nemp (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme Be Tot Son) Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 1 and 2 36 Windsor, Pa 20c. Location - City or Town, Stete Place of Disposition (Name of completery, cremetory or other place) Department of Health Important: If Itam 27 altimore. 20b. 20a. Method of Disposition Pages 1 Buriel 2 □ Cremetion 3 □ Removel from State 6 4 Donation 5 Other (Specify) any injury 22. Name end Address of Facility
Joseph L. KU
ZZZZ W. North ral ZZZZ W.North Aue. To...

ZZZZ W.North Aue. To...

Contain the distance. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting In death) **Examiner** Due to (or es e consequence ot): Examiner ailur ettending physician and for use as the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 98 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 € Unknown þ Division of Vital Records, 24b. Were autopsy tindings evailable prior to completion of cause ot deeth? 24e. Was en eutopsy performed? Completed After this certificate has 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was cese reterred to medicel examiner? Be 28. Piece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) Certification: 28c. Injury at Work? 5 Pending investigation 1 Neturel s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. (Check only one) within 2 To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10/6 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32 Registrar's Sig

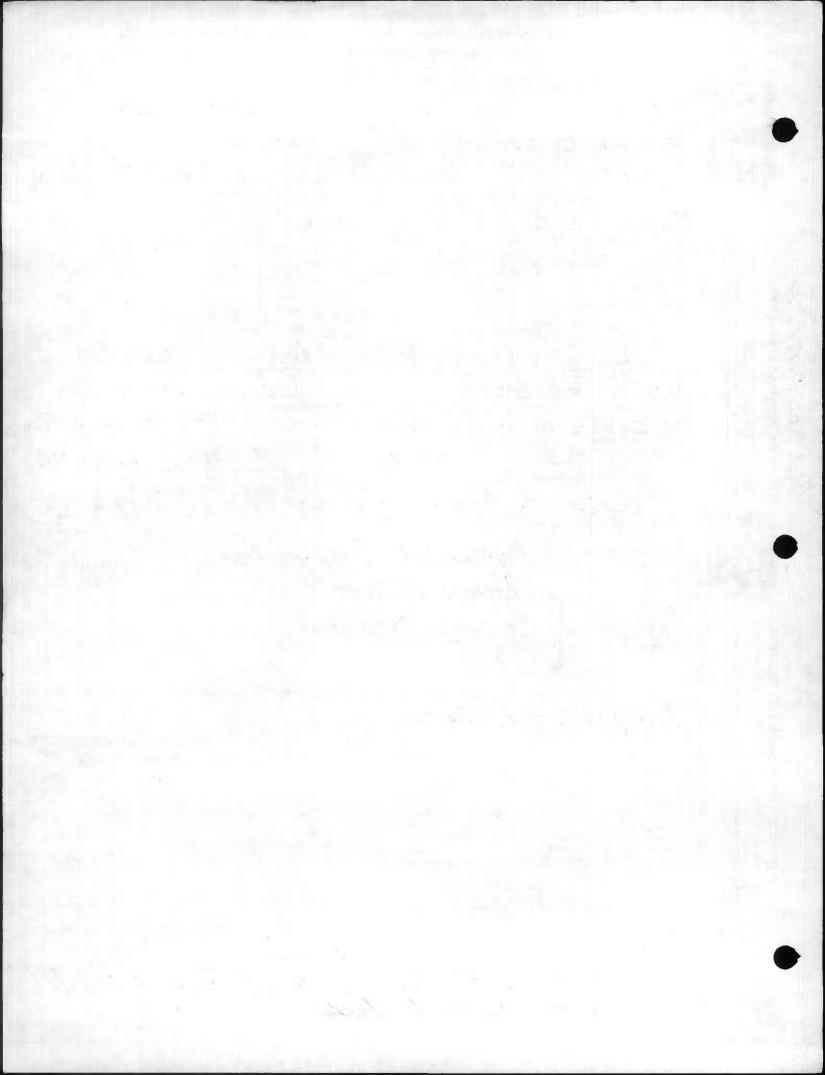
DHMH 16 Rev 6/95

State

Registrar

1 3 1999

OCT



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** Olive Louise Gaspari October 8, 1999 7:00 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 104 Tilghman Avenue Apt. #111 Centreville Queen Annes If Under 1 Yaar If Undar 24 Hrs. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days 1 M 2 F 215-20-7474 Director July 1, 1922 Maryland Usual Rasidence of Dacedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 'natural', or itema 23a or 28a-f show olical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yas 2 € No Director Maryland Queen Annes Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Tilghman Apt. #111 Avenue 21617 U.S.A. death v Funeral 12. Was Decedent Evar in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Pages 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. Int If item 27 Is marked other than "natural", or ite 1 Nevar Marriad 2 Married 1 ☐ Yas 2 □XNo If Yas, Giva Yaar or Datas: altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify P 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Furniture Sewing Machine Operator 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Irving Athey Betha Felton 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Heelth a Important: If itam 27 is any Injury or other tra Ronald R. Gaspari/ Son 289 Lavern Avenue Lansdowne, Maryland 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Meadowridge Mem. Park 10/12/99 Elkridge, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility Signature of Funaral Sarvice License Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical tmmediata Causa (Final disaasa or condition resulting in daath) Examiner Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immadiata cause. Entar Undarlying Cause (Disaase or injury that initiated events rasulting in daath) Last P.O. Box 68760, physician is the burial Part II. Other significant conditions contributing to death but not resulting in tha undarlying causa given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yss 2 ☐ No should be det Records, P 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? page 2 2 No certificate Division of Vital Hospital or Attanding Physician: director, Be 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 522 Rasidence 6 Othar (Specify) edicai Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannag of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 Neturel 5 Panding invastigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by tha 3 Suicida 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar

State Registrar

29b, Signatura and titla of certifian

32. Registrar's Signatura

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

DR. RUSSELL SCHILLING - 2540 CENTERVILLE ROAD - CENTERVILLE, MARYLAND 21617

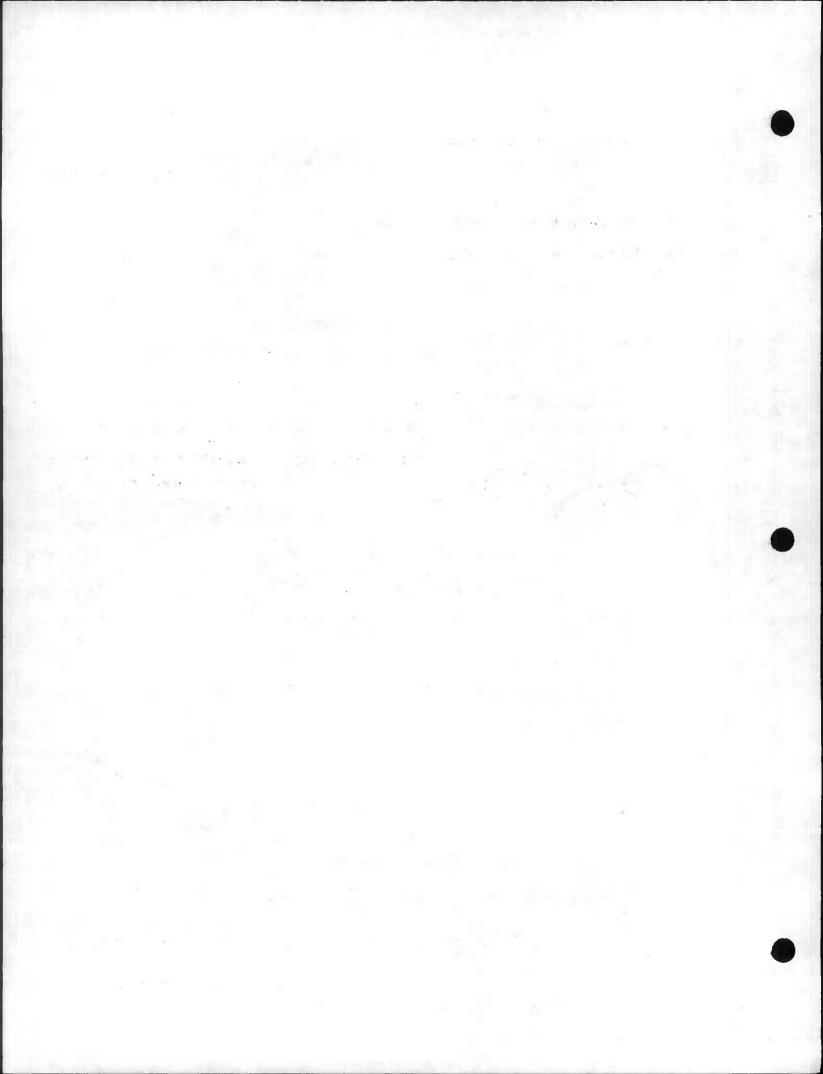
29c. License number

29d. Data signed (Month, Day, Year)

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To Be		Benjamin	Mi	ller					I	da	Shap	iro				
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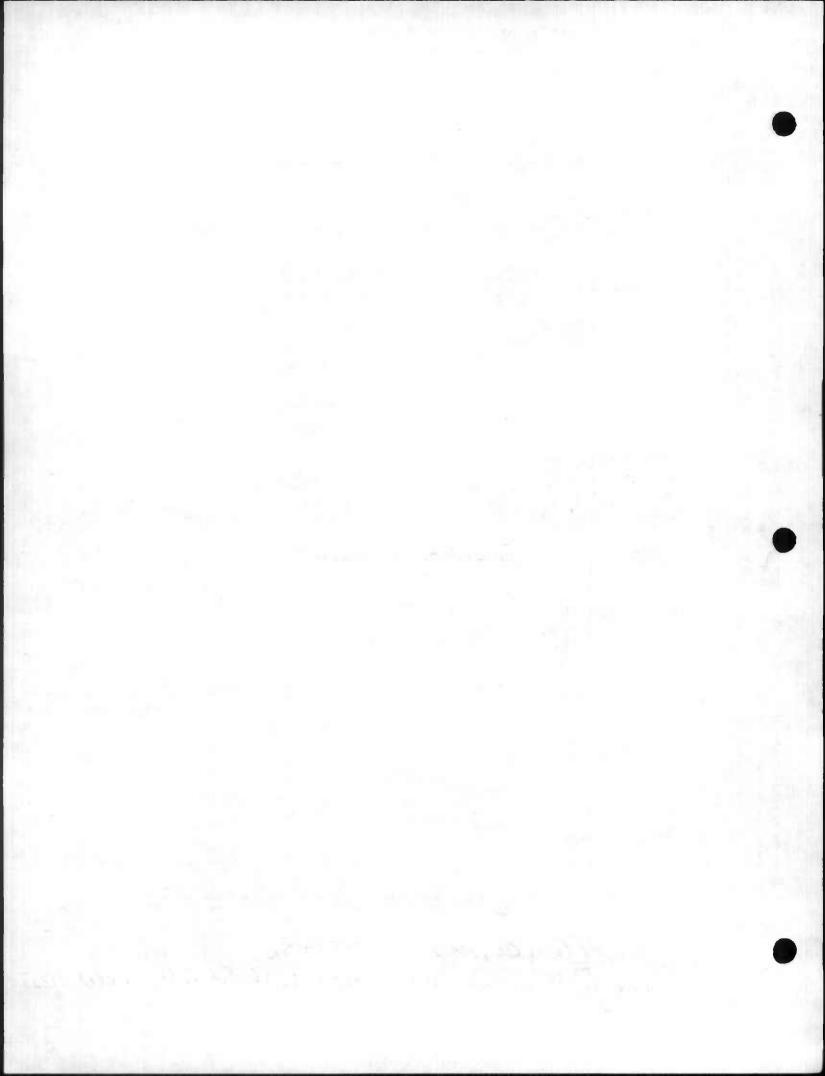
State Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year)
OCT 1 3 1999

32. Registrar's Signatura

Sparker



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 999 Yaar OCT. Physician 4, 1:25AM GERTRUDE EDNA GRAUER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMORE If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1 M 2 TF Months Days 213-16-6972 78 Director JULY 8,1921 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f show MD N/A X Yas 2 No Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 155 GRUNDY STREET APT. 213 21224 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2000 to if Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or han eny injury or other traumatic avent, the Medical Esseminan 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: WHITE Š 3∰Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HAIRDRESSER BEAUTICIAN UKN. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) WILLIAM LUNZ UNK. 19b. Meiling Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TRUDY GELETA - DAUGHTER APT. 213 BALTIMORE, MD 21224 155 GRUNDY STREET 20b. Place of Disposition (Nama of camatery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 10-07-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHARLES S. ZEILER & SON, INC. lenge 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or hear feiture. List only one cause on each line. Approximata Interval Between Onset and Death Physician tmmediate Cause (Finat disease or condition resulting in death) /Medical a. VENTAICULAR FIBRILLATION

Due to (or as a consequence of): MMEDIAIS Examiner Physician/Medical Examiner ARDIOGENIC SHOCK physicien end the buriel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events C. ACUTE ANTERIOR MYOCARDIAL IN PARCTION FOURHOUR The law requires that the deeth certificate be that initiated events resulting in death) Last ATHEROSCURPTIC HEART DISEASE Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPENCHOLISIEROLEMIA Records, þ 24b. Ware autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performad? 0385117 1+ YPERTSN 510 N
25. Was case referred to medical examiner? 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital 80 26. Placa of Death (Check only ona) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28b. Time of Injury 28d. Dascribe how injury occurred 28c. Injury at Work? After Division or Attending 1 Natural 2 Accident 5 Pending investigation deeth. 1 Yas 2 No To the Hospital or Attendit within 24 hours after deeth.
To the Funerel Director: A completely filled in by the fu 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and dua to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 45358 8C1038R

State Registrar

DHMH 16 Rev 6/95

5601 LOCH RAVEN BLVD.

BALTIMORE, MARYLAND 21239

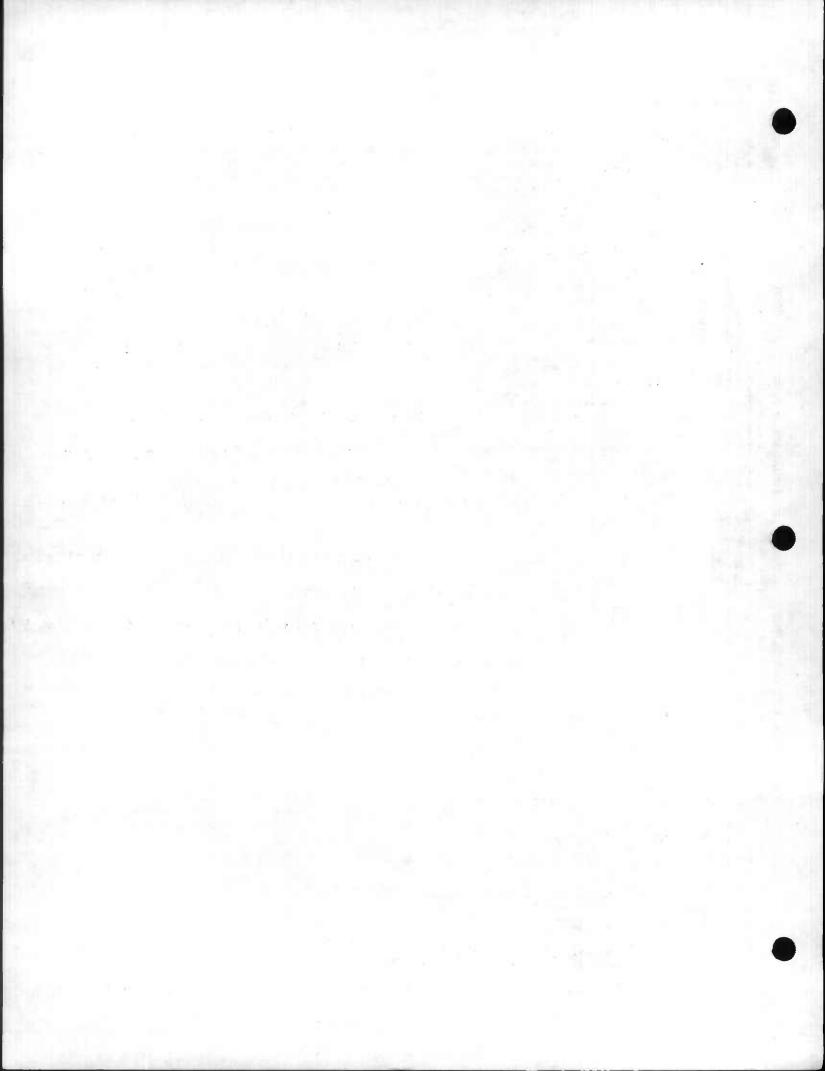
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatura

FONDA

JELLES N.

31. Data filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death OCTOBER 9, 1999 GOLDMAN IDA U. 9:20 AM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDERCARE HERITAGE NURSING HOME DUNDALK BALTIMORE If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Days Min Hours 1□M 2XF Months 212-20-3099 FEB. 21, 1907 MD Usuel Residence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Yes 2 No N/A BALTIMORE 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 3202 OVERLAND AVENUE 21214 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Merried 2 Married 1□ Yes 21 No Specify 3 Widowed 4 □ Divorced WHITE Yaar or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Neme (First Middle Last) 18 Mother's Name (First Middle Maiden Surnama) CHARLES ULRICH LENA (UNKNOWN) 19e. Informent's Name/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARY BUEDEL / FRIEND 3204 OVERLAND AVENUE - BALTIMORE, MD 21214 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete BETH TFILOH CEMETERY 10/11/99 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funary Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haar failure. List only one cause on each line. Approximate Intervat Between Onset and Deeth dan Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseasa or injury that initiated events that initieted events resulting in death) Last Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 TNo 28e. Pleca of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

Examiner physician and the bunal-transit Box 68760. USB P.O. signed by the Records, peen s hes page 2 certificate Division of Vital this or Attending Patter death. After

Physician/Medical by Completed Be 2 Certification:

Physician

/Medical

Examiner

Director

Funeral

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25. Wes case raterred to medical exeminer? 1 Yes 2 No

29e. Certifier

2 Accidant 6 Could not be determined 3 ☐ Suicida 4 Homicida

28f. Location (Street and Number or Rurel Route Number, City or Town, Stata)

(Check only one) 2 Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29d. Data aigned (Month, Day, Year

(E HIGHN 31. Dete filed (Month, Dey, Year)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to tha cause(s) and manner es stated.

State Registrar

Medical

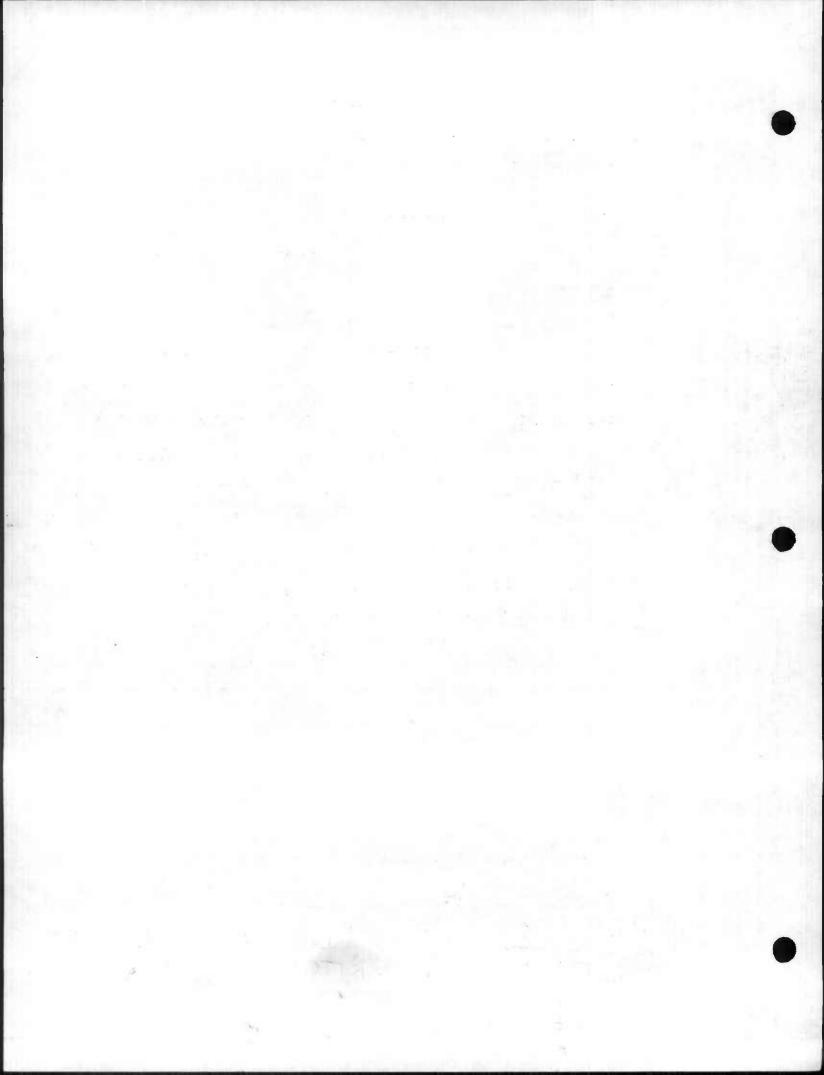
32. Register's Signeture OCT 13

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Gloria Tucciarella Green 11999 10 11:55 AM October /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Singi Los pilel 5. Social Security Number 2401 West Belveder Ave N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2XF Yrs. MAY 15,1926 Director 216-20-3623 73 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director MD BALTIMORE r than "natural", or hams 23a or 28a-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6408 ELRAY DRIVE #D 21209 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other see HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY MATCHER DOROTHY S. SNYDER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD GREEN / HUSBAND 6408 ELRAY DRIVE #D - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW ORTHODOX MEMORIAL 10/12/99 DUNDALK, MD 21. Signature of Politeral Septice Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications transcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Finai Sepsis disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Stuje Renal Disense hysician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Due to (or as a consequence of): 98 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Winknown Hypertension þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen : 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Lo this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending Pi s after death. il Director: After th 28c. Injury at Work? Certification: 5 Pending investigation 1 Watural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 II Homicide within 24 hours of To the Funeral C

Division of Vital Records, P.O. Box 68760 TUCCIARELLA GREEN,

Baltimore, Maryland 21215-0020

State

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29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

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Registrar

DHMH 16 Ray 6/95

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2401 west

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Belveden Are

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

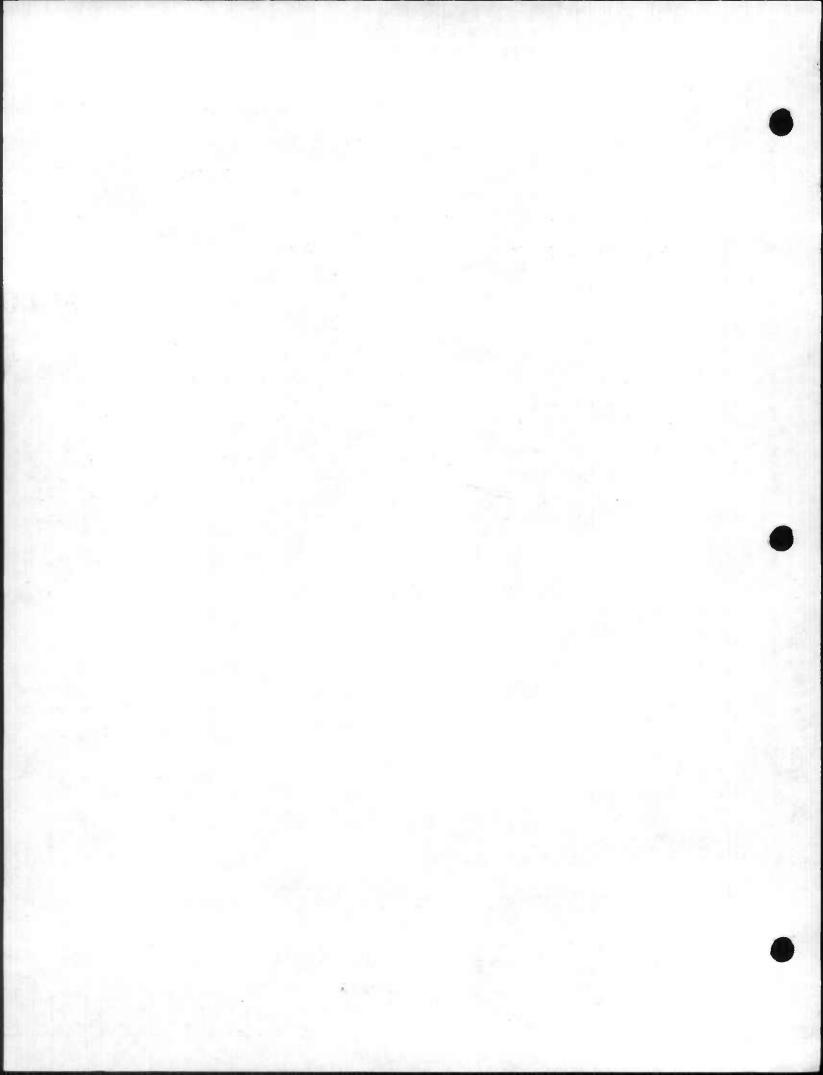
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Bultimore, MO

29d. Date signed (Month, Day, Year)

October 10,1999

21215



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Sri GREENE 1.BER 2110 PM JAMES 1999 8 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner KandallStown HOSPI1A BAL VORTHWES 5. Social Security Number 11MOR 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 242-52-1919 Usual Residence of Decedent Hours Months 10M 20F Yrs. Director 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rati, or items 23s or 28s-f show Examiner mast be notified at Maryland Baltimor 1 XYes 2 No Director 10s. Street and Number 10f. Zio Code 10g. Citizen of What Country? 25 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No MYes, Give Year or Dates; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) C 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) reene 19a. Informant's Name/Relationship (Type, Print Care provider 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walden other Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Department of Important: If h any injury or o Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) 15 Garrison tore 22. Name and Address of Facility 21. Signatche of Funeral Service License Joseph North Ave Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or hear failure. Let only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) UROSEPSIS Examiner PROSTATE Examiner 1851A11C ARCINOMA physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): NSVFFICIENCY KESPIRATORY Physician/Medical Due to (or as a consequence of) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Unknown been signed by should be detac 1 Yes 2 No by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 s 1 ☐ Yes 2010 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funaral 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d, Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death we Funeral Director: A pletely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29e. Certifier Medical completely (Check only one)

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Pages 1 and 2 should be filed within 72 hours after of the filed that that the Mental Hygiene.

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Saltimore,

State Registrar

31. Date filed (Month, Day, Year) OCT 1 3 1999

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

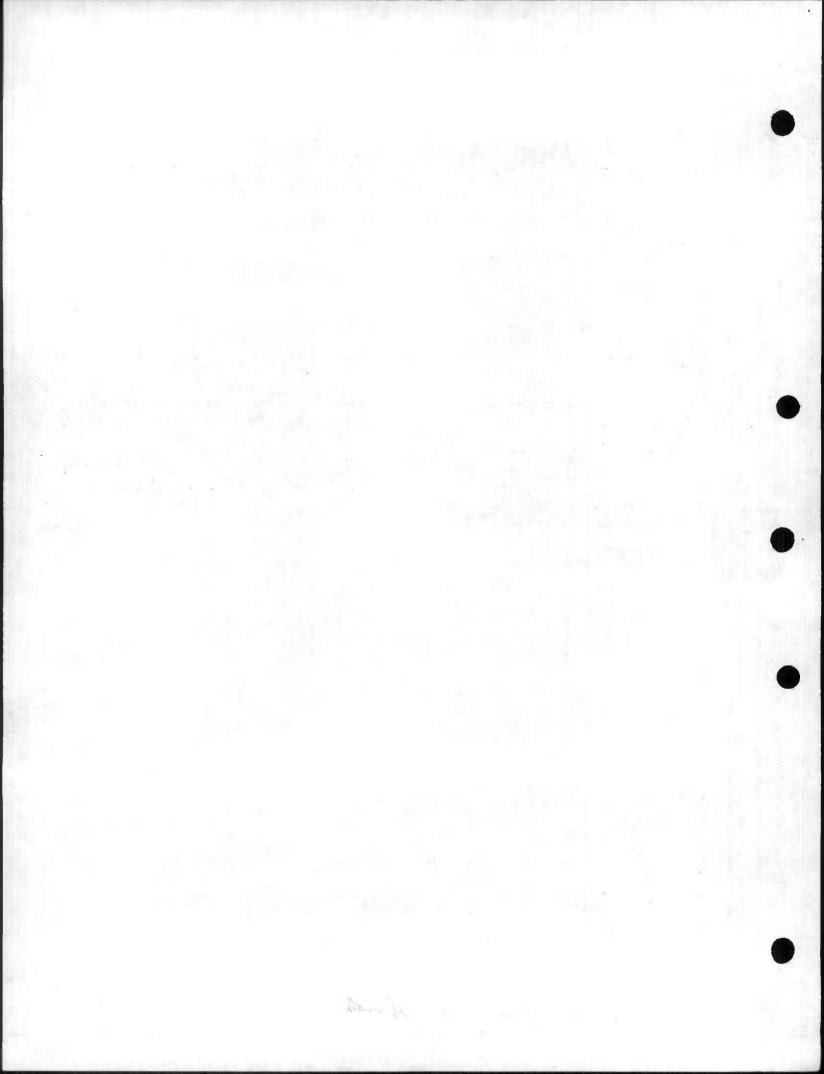
MANATHA SAMONTH 5401 32. Registrar's Signature

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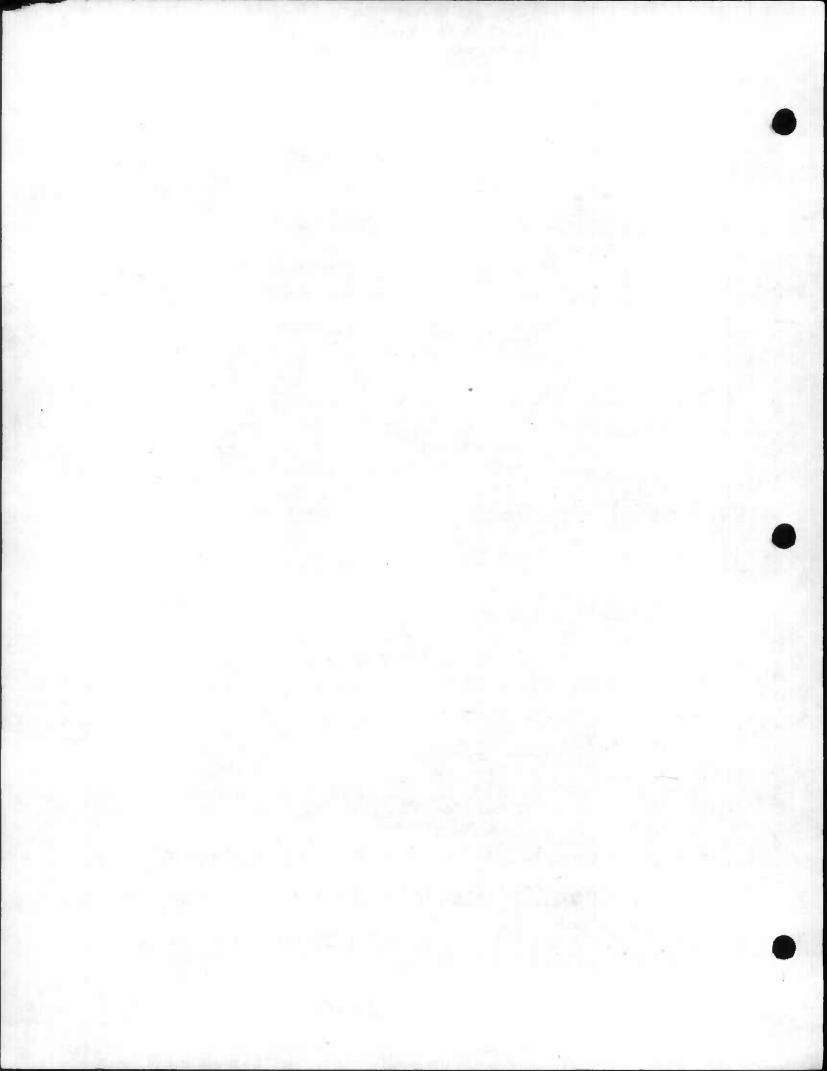
29d. Date signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 9 3 | 8 9 6

			Certificate	of Death	Reg	g. No.	1030
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Funeral Director	5. Social Security Number 216-01-9425 6. Sex	7. Age (In yrs. last birt		Year If Under 24 Hrs Days Hours Min.	8. Dete of Birth (Month, Day, March 18	9. Birt 1914 Ma	hplece (Stete or Foreign unitry) and
Du *	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
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the h	Maryland Anne Arundel		10f. Zip Co	ode	. 100	g. Citizen of What Co	unity?
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death	11 Marital Status 12. Was	Decedent Ever in U,S.	13. Was Deceden	t of Hispanic Origin? (S Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Ame	
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as be	Kenar mourificiency						completion of cause of death?
	Renal Insufficiency Hypertension				1 ☐ Yes	20 No	1 ☐ Yes 2 ☑ No
iclan: The certificate rector, pag				26. Place of De	eth (Check only one)	
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LIVISION OF VICEN In or Attending Physician: 7 In Director: After this certificat ed in by the funeral director, p	3 Suicide 6 Could not be determined 28e.	Placa of Injury - At home, far building, etc. (Specify)	m, street, fectory, o	ffice	28f. Location (Stre City or Town,	eet and Number or Ri Stele)	ıral Route Number,
To the Hospital or Atlandi within 24 hours after deeth. To the Funeral Director: A completely filled in by the f		o the best of my knowledge, the basis of examinetion end manner stated.	death occurred et t Vor investigation, in	the time, dete end place my opinion, deeth occu	o, and due to the cau urred at the time, dat	use(s) and manner as te and plece, end due	stated. to the cause(s)
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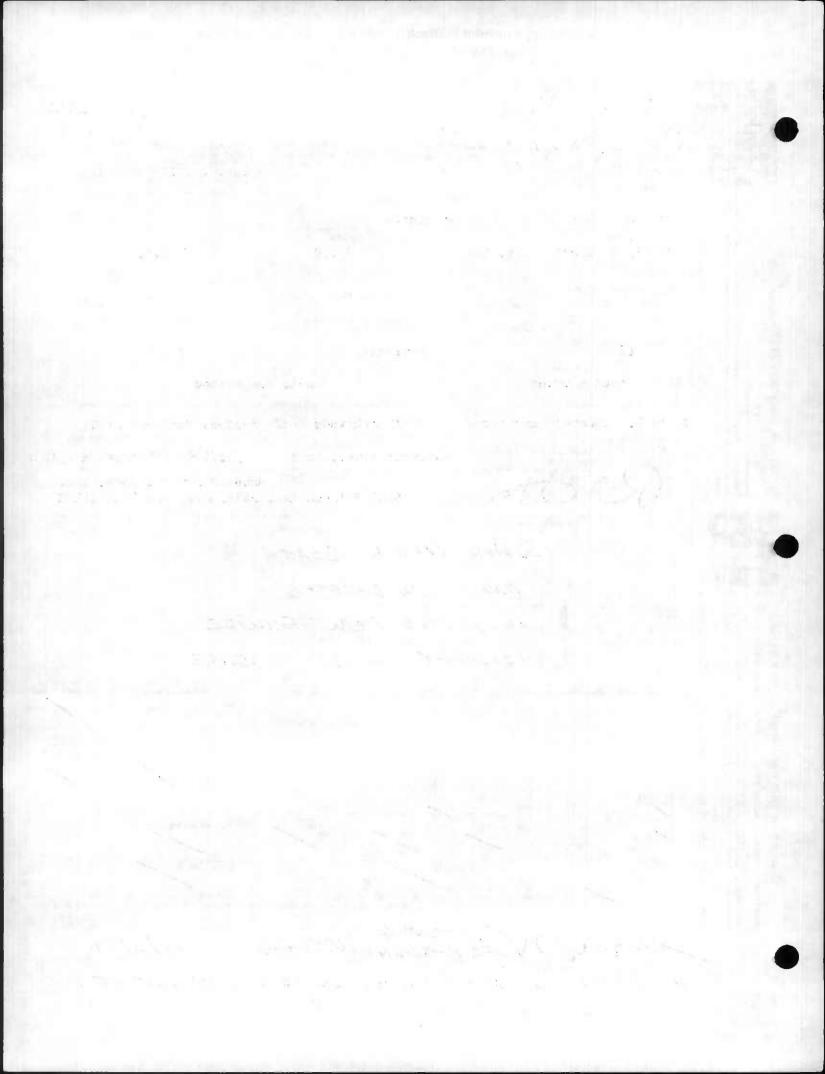


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Registrar DHMH 16 Rev 6/95

32. Ragistrar's Signatura G. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #26,29c,29d, PER MD G776 10/13/99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 1999 Year **Physician** October 4, Charlotte 7:35PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Carroll 339 Lemon Rd. Westminster H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
Months Deys Hours Min. March 10,1930 5. Sociei Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2ØF 215-28-0073 Yrs. 69 MD **Director** Usuei Residence of Decedent the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Carroll MD Westminster 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number r than "natural", or items 23s or the Medical Examiner must be 420 W. Deep Run Rd. 21158 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if frem 27 Is marked other than "natural", or frems 23, any Injury or other traumetic event, the Madical Examiner mass. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify:White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collage (1-4or 5+) Eiementary/Secondary (0-12) Nurse Medical 18. Mother's Name (First, Middla, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 Belle Gordon Sears Joseph F. Zepp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Son 339 Lemon Rd., Westminster, MD 21157 B. Scott Born 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 X Buriel 2 Cremation 3 Removal from State Lake View Memorial Park 10/7/99 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21 Signature of Funerel Service Licensee 11824 Reisterstown Rd. Reisterstown, MD 21136 Eline Funeral Home int1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) **Examiner** Dua to (or as e consequence of): Examine physician and the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to Immadiate ceuse. Enter Underlying Causa (Disaase or injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 60 950 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yss 2 No by 24b. Were eutopsy findings eveliable prior to completion of ceuse of death? Completed 24e. Was an autopsy has 1□Yes 2016 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was cese refarrad to medical examiner? Be 26. Placa of Death (Check only ona) SON'S To. Hospital: Other: 4 Nursing Homa 5 Presidence 8 Other (Specify) HOME 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA this 27. Manner Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c, Injury at Work? Certification: After 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Direc 4 Homicida • Funeral Dire letely filled in b ò Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceusa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and dua to tha causa(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 10/13/99 29c. License number D35390 29b. Signatur

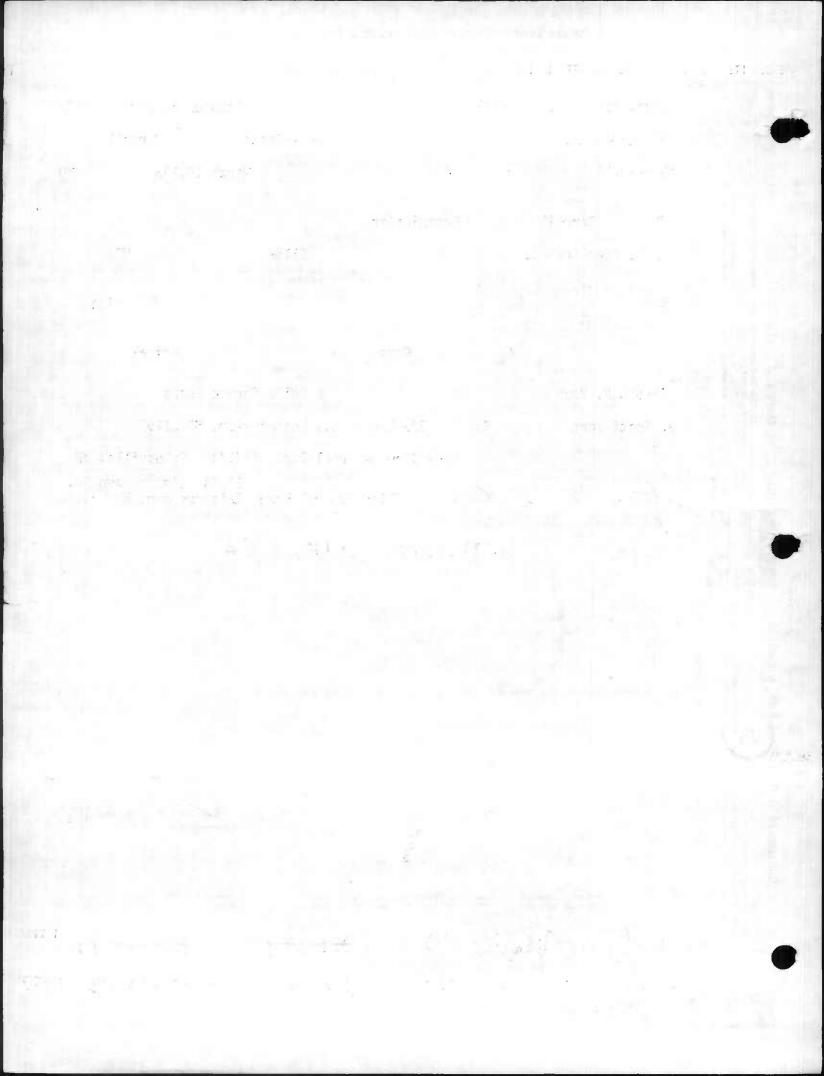
plated causa of death (Item 23a) (Type, Print)

32. Registrer's Signeture

Jashington Leights Westminster Mo 21157

State Registrar

DHMH 16 Rev 6/95

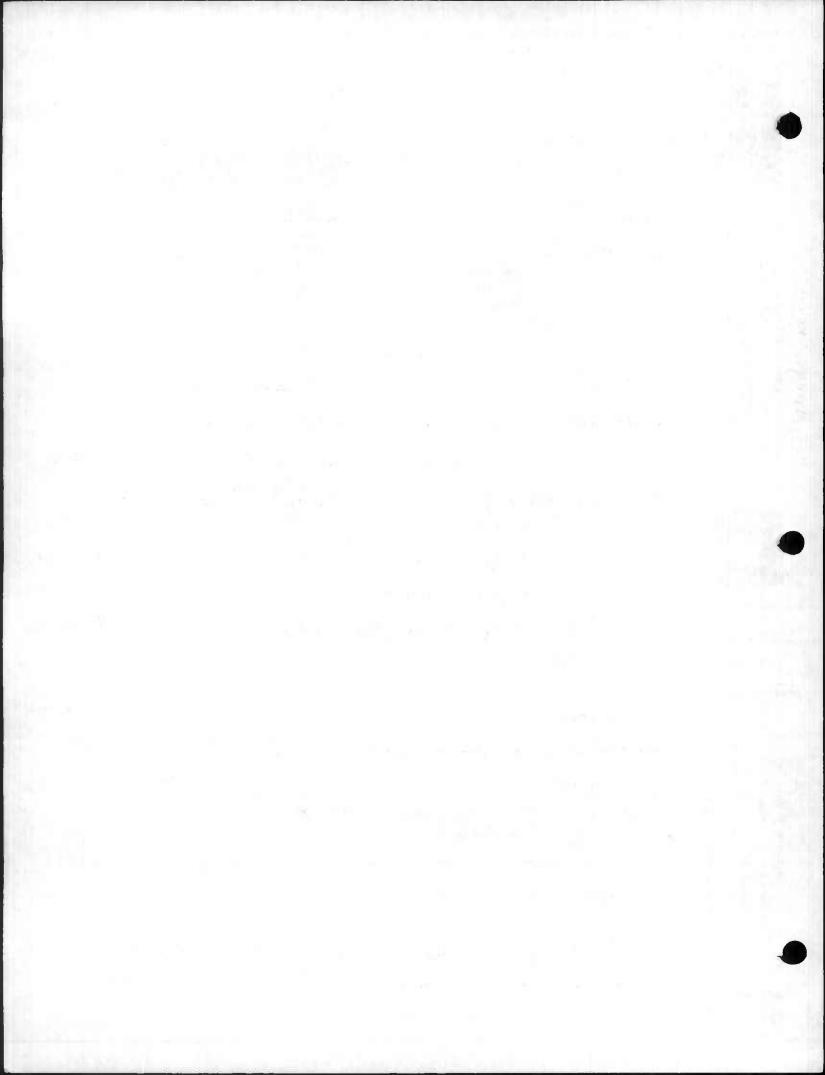


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month Helen Frances Humphreus 10:40 Am 6) 1999 12 /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Nursing Center-Rossville Baltimore If Under 1 Yaar 8. Data of Birth (Month, Day, Year) Feb. 20, 1904 5. Social Sacurity Number If Undar 24 Hrs. 9. Birthplace (Stata or Foreign Country) Maryland 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 95 215-32-8054 Director Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic svent, the Magical Examiner must be notified at Maryland Baltimore White Marsh 1 □ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21162 5402 Bangert Street U.S.A. 2 should be filed within 72 hours eftar daath and Mantal Hygiene. Is marked other than "naturel", or frems 23. Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 X No Specify: þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usuei Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) 12th Grade Collega (1-4or 5+) Homemaker Own Home Humphreys 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be John Finke Josephine Hofmann 19a. Informant's Neme/Raiationship (Type, Print) 19b. Maliing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 Depertment of Haalth au Important: If Item 27 is sny injury or other trau once. Mr. John Humphreys 5402 Bangert St., White Marsh, MD 21162 (son) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ₺ Burial 2 □ Cramation 3 □ Ramovai from Stata Dulaney Valley Mem'l Gard 10/15/99 Timonium, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore,

23a. Part1. Entar tha disaata, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one cause on each line. MD 21236 Approximata Interval Batw **Physician** /Medical Immediata Cause (Final Hypoxemia disaasa or condition rasulting in daath) hours Examiner Dua to (or as a consequence of) Examiner otension The law requires that the death cartificeta be executed the burial-transit Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Diseasa or Injury and Box 68760. ettanding physician thrombosis Weeks Vein Physician/Medicai that initiated avents rasulting in death) Last Dua to (or as a consequence of) signed by the ettending d be dateched for use P.0. Port It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementa Division of Vital Records, þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen Vanconycin resistant Enterococcus 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificata Orine or Attanding Physician: funarel director. 25. Was case rafarrad to medical axaminer? 26. Placa of Death (Check only ona) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Assidance 6 Othar (Specify) 1 Yas 2 No Certification: To Sici 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? Aftar 1 Natural 5 Panding To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte complately filled in by the fun 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 8 Could not ba 3 ☐ Sulcida 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29a, Certifiar i Cortifying Physician: To tha best of my knowladge, daeth occurred at tha tima, data and piace, and dua to tha causa(s) end manner as stated. Medicai (Check only one) 2 Medical Examinar: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, data and place, end due to the ceuse(s) and menner steted. 29b. Signatura and The of certifian 29c. Licansa numbar 29d. Data signed (Month, Day, Year) D53462 WD Dr. Jude Muneses Follston, MD 30. Nama and add ss of person who complated cause of death (Item 23a) (Type, Print) Suite 2112 Belai ROAd 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature State socks Registrar DCT 13 1999

DHMH 16 Rev 6/95



DHMH 16 Rev 6/95

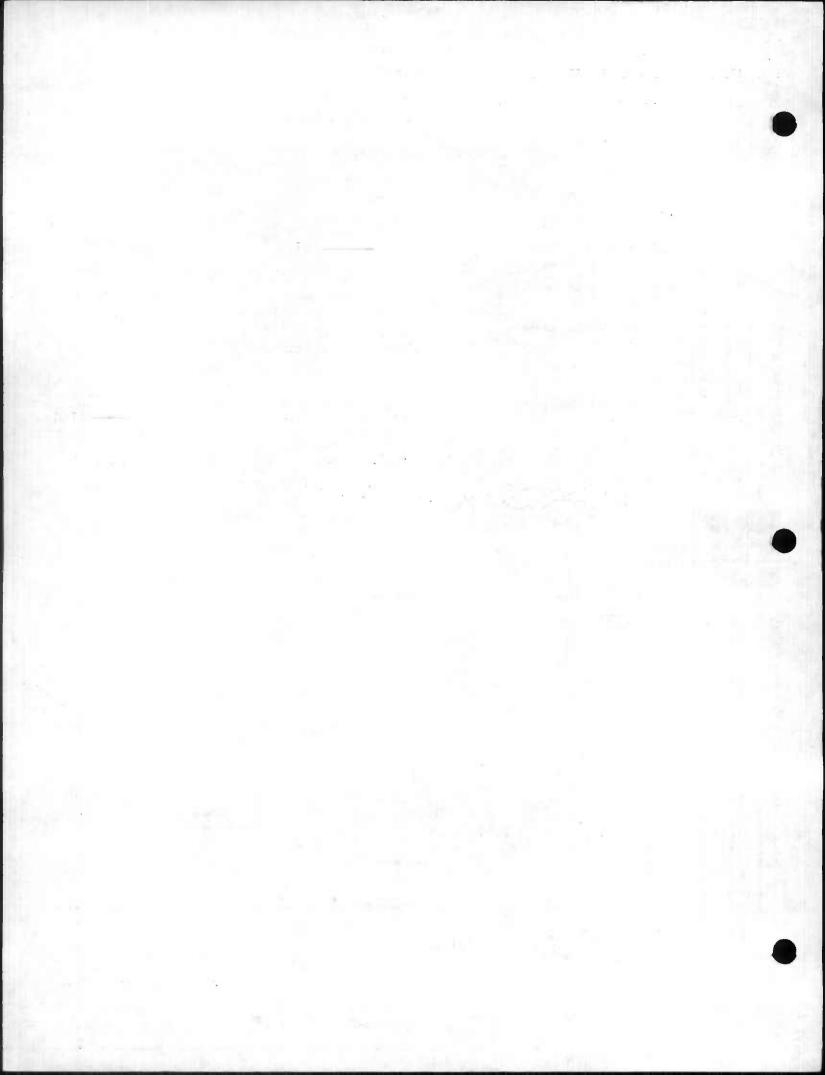
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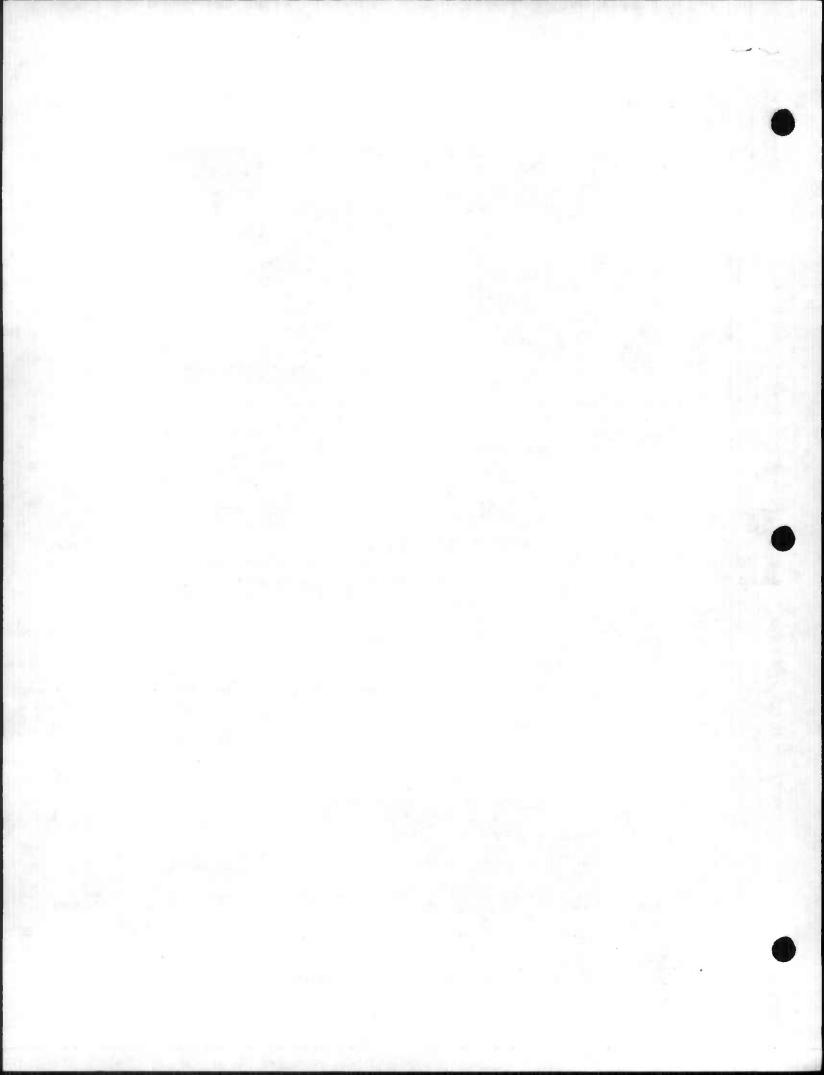
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene 9 3 | 9 0 |

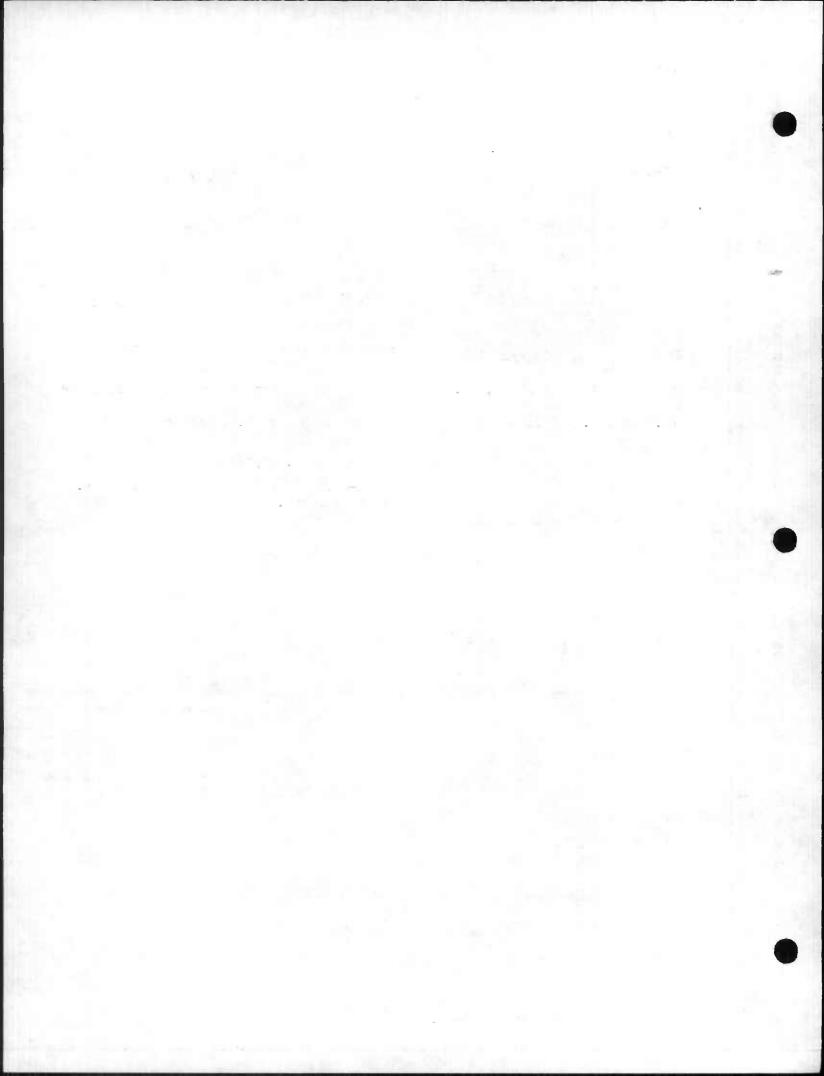
Certificate of Death

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	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	or Location				-		11	0d. Inside City Limit	
Director	Md. How	vard				lumbia					1 ☐ Yes 2 🖄 N	
	10e. Street and Number	3 Fair Oaks		10f. Zi	Coda	2104	44				of Whet Country? ed States	
by Funeral	11. Maritel Stetus 1 Never Married 2 Merri 3 X Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Yeer or Dates:		13. Wes Dece If Yes, spe 1 \(\superscript{\text{Yes}}\)		lispanic Originan, Mexican, I	n? (Specify Ye Puerto Rican,	(Specify Yes or No- into Rican, etc.)		ce - Americ ck, White, o		
5	15. Decedent	's Education	16a. C	Decedent's Usu Give kind of w	el Occup	ation	of working	1	6b. Kind of B	usiness/Ind	lustry	
Completed	Elementary/Secondery (0-12)	College (1-4or 5-		Book	se retired	d)	Working		Auto	Assoc	С.	
BeC	17. Father's Name (First, Middle, L	Last)	,				s Name (First,	Middle, M.	aiden Sumer	ne)		
10	Robert	Johnston				Ma	arie H	larris	son			
	19e. Informent's Neme/Ralationsh Robert Hepner	nip (Type, Print) (Son)		Mailing Addres 1463 Få			or Rural Rout Columbi			, Stata, Zip)44	Code)	
	20a. Method of Disposition 1 🔀 Buriel 2 Cremetion 4 Donetion 5 Other (Sp			Disposition (Ne cremetory or IS Of F	other plea		Dete		Oc. Location		wn, Stete Maryland	
n il r	23a. Pert1. Enter the disease, of shock, or haert feilure. List to shock the shock of the shock	RESPIR	Oue to (or as a co	FAILUR	de of dyir	ng, such es ca		retory erres	st,	ryrani	d 21214 Approximate Intervel Between Onset and Death	
Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	CHRONII	Oue to (or es e co	RUCTIV	E Pl	JLMON	ARY DI	SEAS	BE .	- 1	YEARS	
Medical	Ceuse (Disease or injury that initiated events resulting in death) Last	c	Due to (or es e co	nsequence of):								
Ca	Part II. Other significant condition	se contributing to death bu	t not resulting in t	the underlying	cause civ	en in Pert I	2	3h Did toh	ACCO USO CO	ontribute to	the cause of dea	
y Physician/	Tartil other agricult condition	THE CONTINUE THE CONTINUE TO	t not resulting in	are underlying	Jause giv	TOTAL TOTAL	_	1)X Ye			pebly 4 ☐ Unkn	
Completed by							24	la. Wes an perform		COL	ere autopsy finding allable prior to appletion of cause death?	
-								1 ☐ Yes	2 No	10	Yes 2 No	
						26. Place o	of Death (Che	ck only ona		1		
0	25. Was case raferred to medical											
	examinar?	Hospital: 1 Inpatier		patient 3 D	OA Oth	er: 4 Nurs	ing Homa 5	Rasider	nce 6 Ott	her (Specif)	1)	
To Be	examinar? 1 Yes 2 No 27. Mannar of Death	28a. Data of Injury		me of ury	28c. Injur Wor	y at rk?	28d. D		nce 6 □Ott w injury occur		()	
To Be	examinar? 1 Yes 2 No 27. Mannar of Death	28a. Data of Injun (Month, Dey	Year) 28b. Tir	me of ury M	28c. Injur Wor 1 🗆	4 LI Nurs	28d. D	escribe hov	w injury occur	rred	l Route Number,	
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edical Certification: To Be	examinar? 1 Yes 2 No 27. Mannar of Death Neturel 5 Pending investig 3 Sulcide 6 Could n determine 29a. Certifier (Check only one) Constitution one) Certifying Medical E	28a. Data of Injunction (Month, Dey letion not be ned 28a. Place of Injunction building, atc. g Physician: To the basis of end menner stal	Year) 28b. Tirting ry - At home, fem (Specify) Imy knowledga, examinetion end/	me of ury M m, street, fector deeth occurred or investigation 29 D ype, Print)	28c. Injur Wor 1 D y, offica et tha tir n, in my o	yat k? Yes 2 No	28d. Do 28f. Lo Cá 28f. Lo Cá place, end du occurred at th	cation (Straty or Town, a to the cate time, date time, date 29	eet and Num. Stete) use(s) and m	ber or Rura anner as st end dua to	I Route Number, ated. the cause(s)	



State of Maryland / Department of Health and Mental Hygiene 99

son b. no.	llingsnead			Cei	tificate o	of Death		Re	g. No.		
	1. Decedent's Nama (First, Middle, La.	st)						Data of Death	D	V	3. Time of Deat
Physician		Jason	Boyd I	Hollir	igshead			Month ctober	Day 10, 1	Year 999	08:30
/Medical Examiner	4a Facility Name (If not institution, given Maryland Route 1			Lane		4b. City, Tow	m, or Location		4c. County	of Death	
	5. Social Sacurity Number 6. S		Age (In yrs. las		If Under 1 Ye			Date of Rinth			
Funeral Director		M 2□F	28	Yrs.	Months De		Min.	Date of Birth Month, Day, 1 une 1,			lace (State or Foreity) yland
p .	Usual Residence of Decedent 10a, State 10b, County		40a Cibi	Town as La	estina					14	Od facid. Ob. 11
effer deeth with the Menyland or Neme 23s or 28s-4 show ciner must be notified at Funeral Director		imore	TOC. City,	Town or Lo	cation	Overle	ea			,	0d. Inside City Lir 1 ☐ Yes 2 ☐
or 28	10e. Street and Number		10f. Zip Code					10	g. Citizen of \	What Coun	try?
th wit	424 Meadow Road					21206	5		Unite	d Sta	tes
her deet	11. Marital Status	12. Was Decede		. 13. \	Vas Decedent	of Hispanic Orig Cuban, Mexican,	in? (Specify	Yes or No-		e - Americ	
by Est	1 ☐ Navar Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2[If Yes, Give Year or Date	No		Yas 2⊠		Puano Hica	n, etc.)	Specify	ck, White, V: Whi	
"netural".	15. Decedent's Ed	lucation		16a. Deced	lent's Usual Oc	cupetion	of working	10	6b. Kind of B	usiness/Inc	dustry
within then.	(Specify only highest gra	College (1-4d	or 5+)	life. L	OO NOT use re	one during most tired) echnicia			Commun	icati	ons.
Hydra CO	17. Father's Name (First, Middle, Last)	1 Year				18. Mother	's Name (Fi	st, Middle, Mi	aiden Sumen	ne)	
Mentel H Mentel H mrked out matic sver			Tan								
2 should by and Mente Is marked sumatic at TO E	Harry Leroy Holli			10h M=10*-	a Address (C)	reet and Number		e Rae I			Code!
d 2 sho	19e. tnformant's Name/Relationship		ife								
Heelth Heelth em 27 I	Mrs. Kerri N. Hol	lingsnea				Road C				2120	
permit. Pages 1 and 2 Department of Heelth a Important: If frem 27 is any folury or other tra once.	20a. Method of Disposition 13 Buriat 2 Cremation 3 4 Donation 5 Other (Specify		rie cen	natery, cren	sition (Neme or netory or other of Fail	place) Th Cem.	1		0c. Location -		
permit. Pa Departmen Important: any folury once	21. Signature of Funeral Sarvice Licen	S00)	22	Duda-Ri	Idress of Facility	eral H				
	23a. Part1. Enter the disease, or com	disations that saw	and the death	Do not ent		ise Ave.				nd 2	Approximate
eeth certificate be executed attending physician and for use as the burial-transit cian/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or trijury that initiated events resulting in death) Last	b	Due to (or a								
th certific thending p or use es		d								t	
ires that the death cert signed by the attending to be detached for use d by Physician/N	Part II. Other significant conditions or	ontributing to death	stributing to death but not resulting In the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of			
been signed should be de leted by								24a. Was an perform		av	ere autopsy findia ailable prior to mpletion of cause
has 36 2						18		1 PT Yes	2 🗆 No	of	death? ≧Yes 2□ No
certificate rector, pag	25. Was case referred to medical					26 Place	of Dooth (C)	neck only one			
yarcian: is certific director, To Be (examiner? ★S Yes 2 No	Hospital: 1 ☐ Inpa	ations OFF	D/Outnotion	1 3□ DOA	Other:				as (Canail	ul /Coon
	27. Manner of Death	28a. Date of I		R/Outpatien 8b. Time of Injury		njury at Work?	28d.	5 Rasider Describe how	w injury occur		(Scen
Attending r death. ector: Afte by the fune iffication	2. Accident investigation	10 10	1-99	075	M I	1 ☐ Yes 2 ☐ N		wo -			13.60
is of a standing in a standing of a standing of the standing o	3 Suicide 6 Could not be determined	28e. Place of	Injury - At hom etc. (Specify)	d N A		ice	281.	Location (Stre City or Town, RT		ber or Rura	al Route Number,
To the Function of Amended in whithin 24 hours after death. To the Function Director: After the completely filled in by the functional Medical Certification:	29a. Certifier 1□ Certifying Phy (Check only one) 1□ Certifying Phy (Check only one)		st of my knowle of examinetion	edge, death	occurred at th				use(s) and ma		
Within Young	29b. Signature and title of certifier	181			29c. Lic	ense number		29	d. Date signe	d (Month,	Day, Year)
- > - 0	4	151			0.0	C.M.E.			Octobe	r 11,	1999
1	30. Nama and address of person who	- /-	of death (Item 2								
•	10-	onler			Penn St	treet, E	Baltim	ore, M	arylan	d 212	201
State Registrar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signatur	ra	4 /						



Please Type or Pri	int in Black Indelible Ink. Assure All (Copies Are Legib	le.
State of M	faryland / Department of Health and Me	ntal Hygiene	3
	Certificate of Death	Reg. No.	-
Tinna Adiddle Local		6 1 1 4 6 1 4	

			Decedent's Neme (First,	Middle, Las		iaiyiaiiu /		tificate of	Health and M Death	R 2. Dete of Dee	eg. No.	3	9 0	3 of Deeth
	Physic /Medi		PAULIN	Ξ]	HAUSI	OORFF		October	11, 199	9 ^{Yeer}	3:21	a.m.
	Exami		4e. Fecility Neme (If not inst Sinai Hospit						4b. City, Town, or Lo		4c. County	of Deeth	N/A	
	Funeral		5. Social Security Number	6. S		ge (In yrs. last b	irthday)	If Under 1 Year		8. Dete of Birth	1	o Rirthi		or Famion
	Director		503-16-8252 Usual Residence of Decede		□ M 21 X F	76	Yrs.	Months Deys	Hours Min.	(Month, Day	Year)	Coul	olece (State otry)	D.
	and and		10e. State 10b. Co			10c. City, Tov	wn or Loca	ation				Τ.	IOd. Inside (City Limits
	ith the Marylar or 28a-f show	Po	MD 1	BALTI	IMORE BALTIMORE									s 2X No
	28a	Director	10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Co									het Cou	ntry?	-
	23a or		6502 WICKF:	TELD I	ROAD				21209		9 0112011 01 11	1101 000	U.S.	Δ.
	Items 2	Funeral	11. Marital Status		12. Was Decedent	Ever in U,S.	13. W	as Decedent of		ecify Yes or No-	14. Rece	- Ameri	can Indian,	
1	urs after death with the Maryle all, or thems 23a or 28a-f shor Examinet mult be notified	by Fur	1 Never Married 2 X	Armed Forces 1 ☐ Yes 2 If Yes, Give		Yes, specify Cul □ Yes 2 X No		ispanic Origin? (Specify Yes or No- n, Mexicen, Puerto Rican, etc.) Specify:			etc. WHIT	E		
3	"natural",				Yeer or Dates:	10.	Danada	natio Univel Cons			101 1/1-1-1 0		4	
20000	withir sne. than	Completed	(Specify only) Elementary/Secondary (0-	12)	College (1-4or	0+)	16a. Decadent's Usuel Occupetion (Give kind of work done during n iffe. DO NOT use retired) OWNER			ing	16b. Kind of Bu			
wa ylaila	s i and 2 should be filed f Health and Mentel Hygis tem 27 is marked other other traumatic event, ii	To Be C	17. Fether's Neme (First, Mic NATHAN	ddle, Last)		KOPLO	N		18. Mother's Name	e (First, Middle, I	STAMP STORE , Maiden Surname) HALPIRN			
5	2 shot 8 end 8 ls mai		19e. Informent's Name/Rela	tionship (7	Type, Print)	19	b. Mailing	Address (Stree	et end Number or Rure	al Route Number	, City or Town,	State, Zij	Code)	
	alth e 27 is 27 is or train		HENRY HAUSDO	DRFF	/ HUSBAND	6.	502 V	NICKETEL	D ROAD -	RALTTMOR	E. MD 2	21200		
Dalimione,	permit. Pages 1 and 2 Department of Health e important: If item 27 is any injury or other tra once.		20e. Method of Disposition XXBuriel 2 Crema 4 Donetion 5 Oth 21. Signature of Funeral Se	er (Specify	")	cemete	A AHA	ition (Neme of afory or other pla AVAS CHE Name end Addr	ESED sess of Fecility	10/11/99 OL LEVIN	ISON & E	ALLS	STOWN,	
	Physician		23a. Perty. Enter the disease shock, or heart failure.	e, or confine	olications thet cause one cause on each l	d the deeth. Do ine.	not enter	the mode of dy	ERSTOWN RO	OAD — PI or respiretory err	KESVILL est,	E, N	Approxime Intervel Be Onset end	ate
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)		Metast	atil Re	nal	Cell Car	ncer				11 mo	nths
	330	-e	resulting in security			Due to (or es e	consequ	enca of):						
,007	certificate be executed ding physician end use es the buriel-transit	Examiner	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	5	b. —	Due to (or es e	consequ	enca ot):						
0	tificate b ng physic es the bi	edical	thet initiated events resulting in deeth) Lest	1	c.	Due to (or as e	conseque	ence of):						
X	ath cer attendin for usa	N/Jue			d									
0	death na atter ed for u	sicia	Pert II. Other significant con	nditions co	ontributing to death b	out not resulting	In the und	derlying cause g	iven in Pert I.	23b. Did to	bacco use con	tribute t	the cause	of death?
	that the de ned by tha a	by Physician/M	Renal Insuf							1 □ Y	2 No	3 Pro	bably 4	Unknown
2000	a law requires has been sign je 2 should be	Completed b	Atrial Fibr	illat	ion					24e. Wes e perform		ev	ere eutopsy eilable prior mpletion of deeth?	to
	0 5 0	200								1 🗆 Ye	s 2XNo	1 [∃Yes 2[] No
	ician: The certificate rector, pag	Be (25. Wes case referred to me exeminer?	dical					26. Plece of Deet	h (Check only on				
11	S S	70	1 Yes 2 No		Hospitel: 1 Unpati	ent 2 ER/O	utpetient	3□ DOA O	ther: 4 Nursing Ho	me 5 ☐ Reside	nca 6 Othe	r (Specil	(y)	
	Attending Ph ir daeth. ector: After th by the funeral		27. Menner of Deeth 1 Neturel 5 Per 2 Accident	ending vestigetion	28e. Dete of Inju (Month, De	ury 28b.	Time of Injury	28c. Inju We M 1	ork?	28d. Describe ho	w Injury occurre	ed		
DIVISION	for Atta efter dad Director d in by th	ertification:		ould not be etermined	28e. Piece of in	jury - At home, f lc. (Specify)	erm, stree	et, fectory, offica		28f. Location (St City or Town		or Or Rur	al Route Nu	mber,

To the Hospital within 24 hours
To the Funeral completely filled Medical (29a. Certifier (Check only one) 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

October 11, 1999 Res000

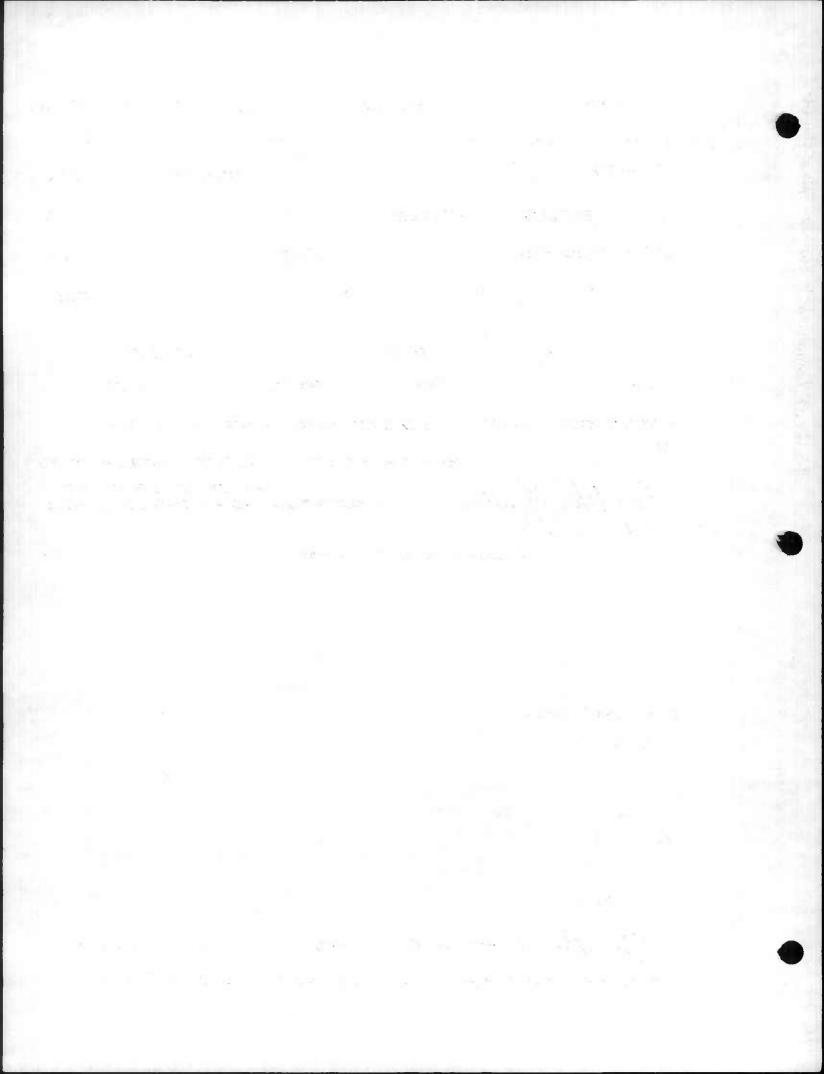
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Avery Davis, Dept of Physical Med & Rehab, WRAMC, Washington, DC 20307

State Registrar

31. Dete filed (Month, Day, Year) 32. Registre Signature





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Tima of Death Month **Physician** Edward 1999 Hughes lie October 9:05 /Medical 4o. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Saint Agnes 5. Social Security Number 6. Se Baltimore If Under 24 Hrs. 8. Dete 8. Dete of Birth (Month, Dey, Year) 10 S P 1 tal 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Yee 6. Sex **Funeral** 12M 20 F Months 218-05-005 84 Yrs. Director Usual Residence of Decedent with the Maryland 10a. Stete 10d. Inside Gity Limits 10b. County 10c. City, Town or Location 23a or 28a-f show 1 Yes 2 No **Funeral Director** noce 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code 229 SA Koad Rema : 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritel Stetus Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 ☐ If Yes, Give Year or Detes: 2 No 8 21215-0020 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 Widowed 4 Divorced Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Worker altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Department of Health and Mental Hy Important: If item 27 is marked oth sny Injury or other traumatic avent pncs. Willie Man Bridges Hughes 19e Informent's Neme/Relationship (Type, Print) W; fe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wicklow Rd. Baltimore, MV. LILA Date 20d. Location - City or Town, State mD. 21229 orrine Hughes 20e. Method of Disposition Burial 2 Cremetion 3 Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Garrison Forrest Veterans Oct. 14 Owings Mills, 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Nutter Fureral Homes, Inc. 21. Signeture of Funerel Service Licensee 2501 Gwynns Falls PKWy Baltimore, mo. 21216 Lutter 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel MUCCARDIAL disease or condition resulting in death) 30 MNITES **Examiner** Due to (as e consequence ot): Physician/Medical Examiner 10 YEARS Atheroscienotic CARDOVASCULAR The law requires that the death certificate be axecuted use as the bunal-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably 4 Unknown 1 Yes 2 No DERTENSION 2 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed After this certificate has 202 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 31 DOA 1 Inpatient 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel after death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29e. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar as steted. completely (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 1999

32. Negistrar's Signature

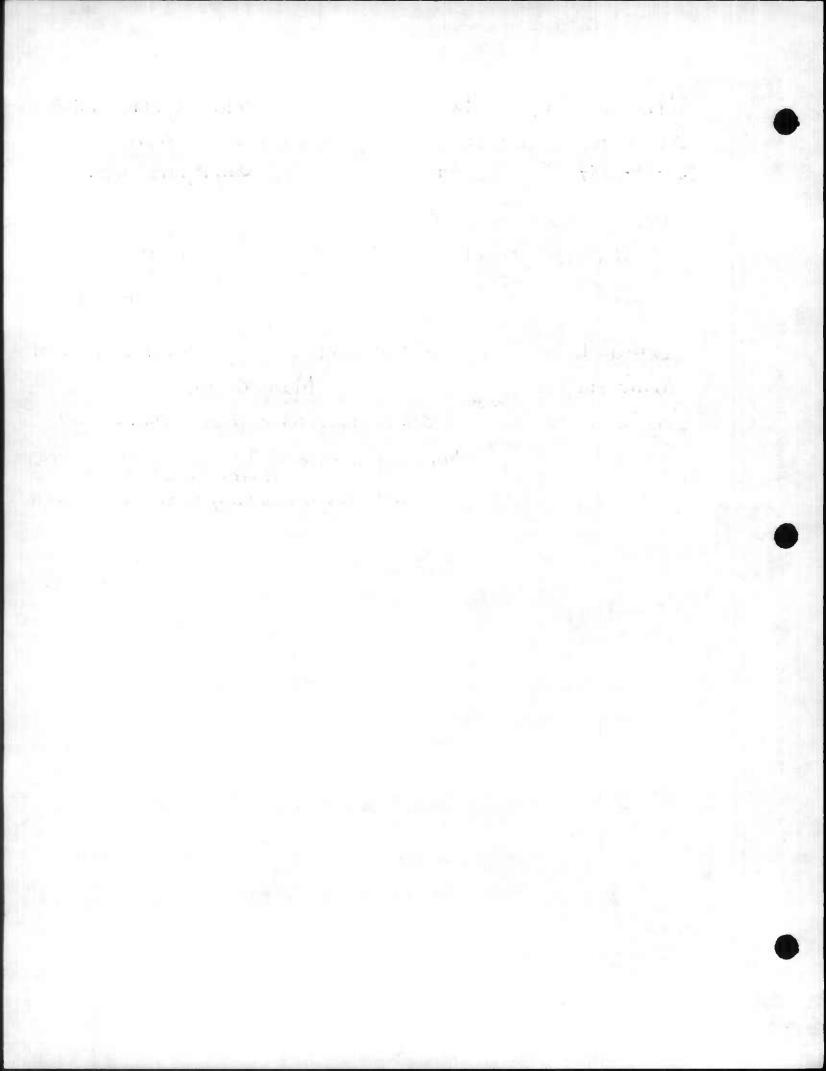
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

erome

· Ongoler MD

5 outh Caton AVENUE BALTIMORE, MARYCAND 9. Sporks

222648



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 10:20PM DOROTHY HANFY HO 4a Facility Name (If not institution, give street and number) 1c1 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner ATOUSVIL Under 24 Hor ATOUSVILL Social Security Number OMMONS LE MORE 6. Sex 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Days Months Hours Min. 2/5-0/-/688 Usual Residence of Decedent Yrs. MARYLAND Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE Director ETHORPE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 4609 "natural", or Items 23a NITED 14. Race -Funeral TUENUE unic Origin? (Specify Yes or No-Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?
1 Yes, Give Year or Detes: 11. Marital Status 13. Was Decedent of Hist Black, White, etc. ecify Cub 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) pernit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene Important: If Item 27 Is marked other than "r. any Injury or other treumatic event. In Mental Control of the Mental Country or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) KEAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 206. Place of Disposition (Nar cemetery, crematory or o (EMETERY 10-13-1999 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Service Licensee Do not enter the mode of dying, such as cardiac or respiratory errest, 23a. Part1. Enter the disease, or complications that caused the doubt, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** THEROSCENOTIC CANDIO VASCULAR /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner OEK TEXISION Examiner 12 ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the Due to (or as a consequence of): 180 Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 4 Unknown 1 Yes 2 No 3 Probably by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 20 No 1 ☐ Yes 2 TNo certificate or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) 20 No Hospital: Other: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 27. Menner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signatura and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

f

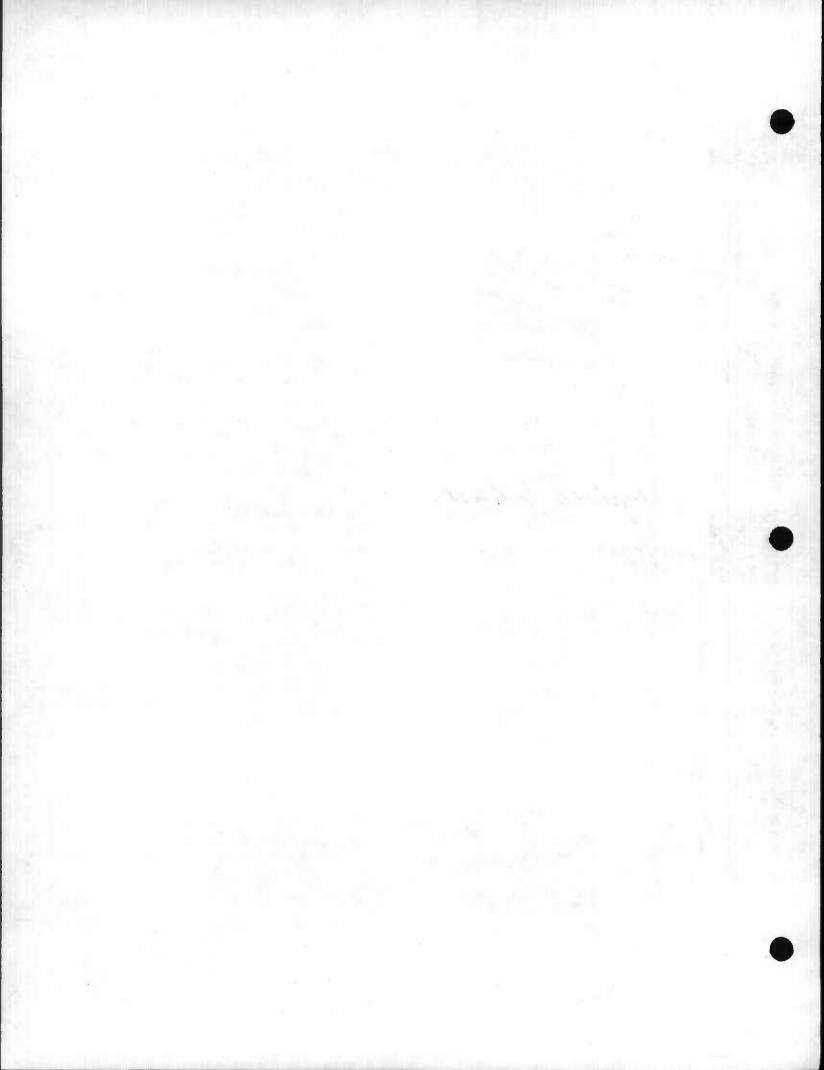
29d. Date signed (Month, Day, Year)

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ysician ledical	REMONA SALLY	IERVELL	0			oction 6	, Day 999 Year	6:30am
aminer	4s Facility Name (If not institution, give 108 N. HAVEN				4b. City, Town, or L BALTIM		4c. County of De	ath
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ral Director	MD. N/A]	BALTIMOR	E				1 No 2 No
Director	10e. Street and Number	שממ משם		10f. Zip Code	224	1	0g. Citizen of What (Country?
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ToB	WILLIAM MILES	McGEE			SARAH	JANE NU	INAMAKER	
	19a. Informant's Name/Relationship (1						City or Town, State	
	MELISSA IERVE	LLO/ DAUGH	20b. Place of Dispo		VEN STRE		20c. Location - City of	MD. 21224
	1 ☐ Burial 2 ☐ Cremation 3 ☐		CHESAPEA	natory or other pl	MATORY 1		BELTSVII	
	4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	"		. Nama and Addi	i	0/12/3		
Duc Buck	1 1 1	1 2	/ /	TT DT DO	a anti	ER & SC	N INC	
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ian	The second secon							Onset and Death
al er	Immediata Cause (Final disease or condition resulting in death)	. Mela	, sich c	- hor	smell	coul	ung come	ele
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Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		emite	4 . 4	entri	ubpe	eihnee	e
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lan		0						
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Completed b						24a. Was a perfor		Wara autopsy findings available prior to complation of causa of death?
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B C	25. Was case referred to medical				26. Place of Dea	th (Check only or	96)	
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	27. Manner of Death 1. Natural 5 Pending	28a. Data of Injury (Month, Day)	(ear) 28b. Time o	28c. Inj W	ury at ork?	28d. Describe h	ow injury occurred	
catio	2 Accident Investigation			M 1[Yes 2□No			
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edical	(Check only 2 Medical Exam	niner: On the basis of a and manner state	d.	vestigation, in my	opinion, death occu	red at the time, d	ate and place, and d	ue to the cause(s)
Medical Ce	29b. Signature and title of certifier	0-		29c. Licer	nse number	2	9d. Date signed (Mo	onth, Day, Year)
	Ireline	120ce	m1)	1) (1826		10/8/	5
	30. Name and address of person who	completed cause of dea		Print) m	Paul Me	1-0	01: 00	MI) 4202
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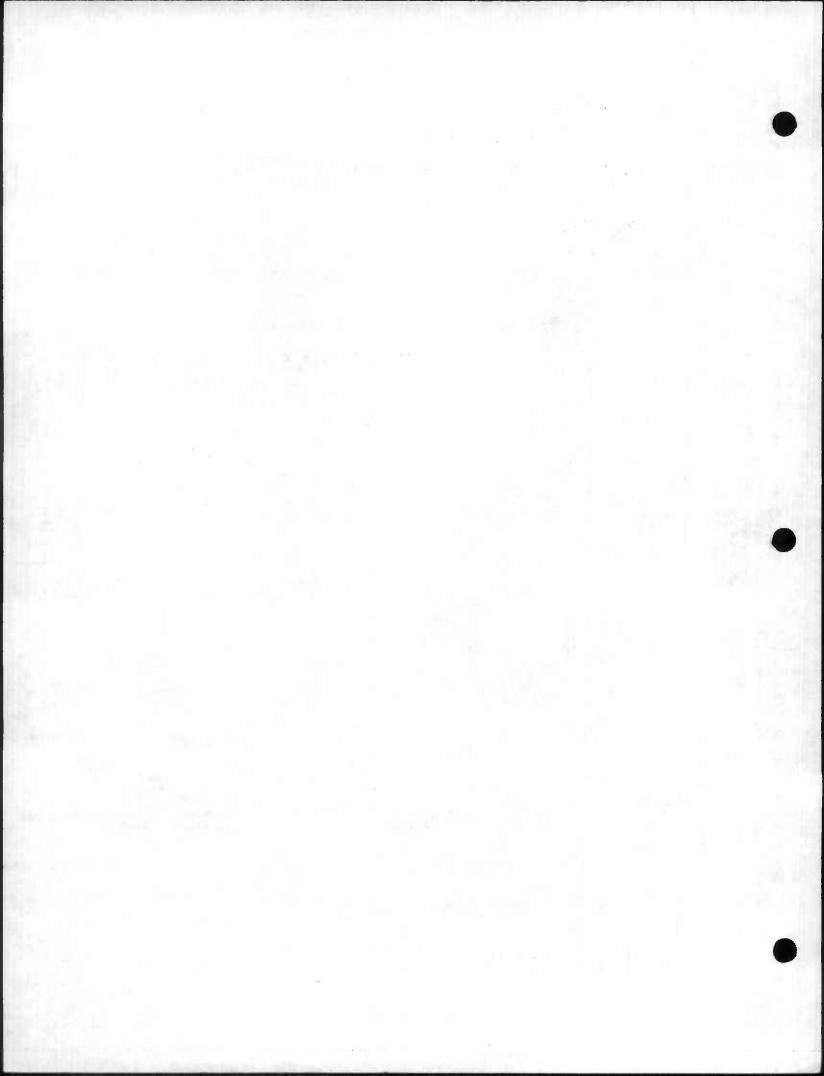
State Registrar DHMH 16 Rev 6/95



AMEND	Jergenson ITEMS: #23 F	PART :	State of M. I., 27, 28.	aryland A-F	Deparent PERCer	tificate	of L	ealth <u>:</u> Death	and by	lental Hyg	gieneg g	3	1907	
	1. Decedent's Neme (First, A									2. Date of Dea Month		Year	3. Time of Death	
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Funeral Director	5. Sociel Security Number 216-56-6280 Usual Rasidence of Daceder		M 200 F 40		Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day July 8,	1950	9. Birtho Coun Mary	lace (State or Foreign try) Land	
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th with th	Maryland Ha 10e. Street and Number 2957 Kirkwal 11. Marital Status 1 Never Merried 28	l Cour	t			101. Zip 0					U.S.A.		try?	
urs s	3 □ Widowed 4 □ Divo	Merried	2. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Yaar or Datas:			Vas Decede I Yes, specil		spanic Ori n, Mexical Specify:		ecify Yes or No- Rican, etc.)	14. Rai Bla Specif	ck, White, white	etc.	
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1 and Health Health on 27 ther tr	20a. Method of Disposition	riseri (nasvanaj	20b. Pla	ace of Dispo- metery, cren				nu,		20c. Location			
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The lew requires the late has been signed page 2 should be discontinued.										24a. Was a		av:	ere autopsy findings ailable prior to mpletion of cause death?	
The lew ate hes bage 2 s										No	'es 2□No	10	Ves 2□ No	
ysicien: The ysiciente director, pag		dical						26. Place	e of Deat	h (Check only o	ne)			
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To the Hos within 24 ho To the Fun completely		ctifiper	~ (HOHIOI 5(I	own.		29c.	License	number			29d. Date signe	ed (Month,	Day, Year)	
F \$ F 0	Claro	Lole	eins				0.0	C.M.E			Octob	er 8,	1999	
	30 Name and address of per	son who cor	npleted cause of d	leath (Item	23a) (Type, 1		Peni	n Str	eet,	Baltim	ore, Ma	rylan	d 21201	

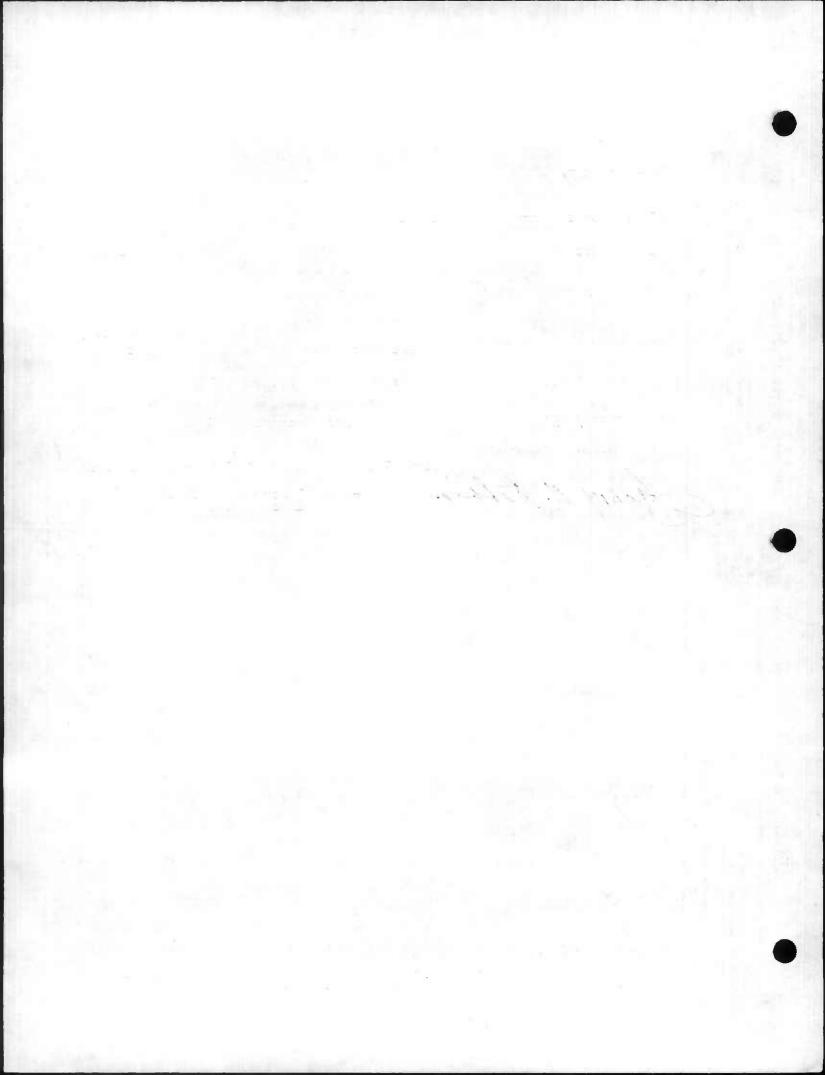
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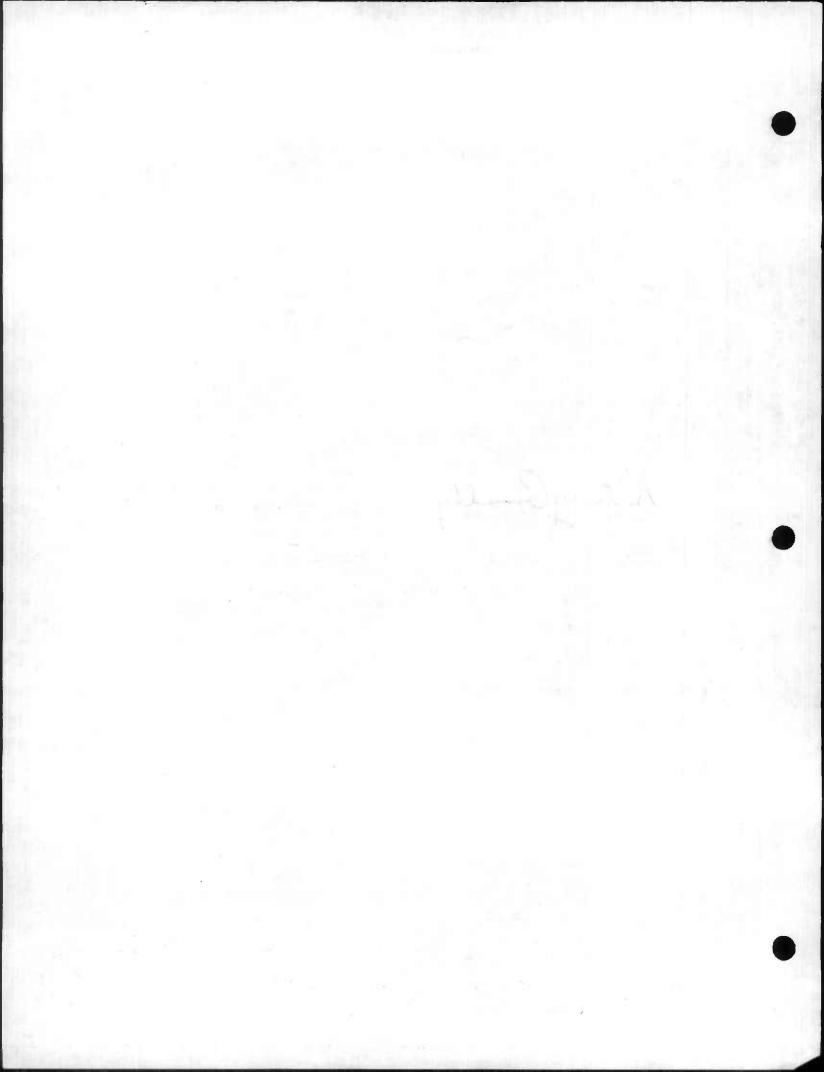
State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Facility Name (If not institution, giv	e street and number)				4b. City, Town, or Lo		4c. County of				
	7 Echo Court 5. Social Security Number 6. S	7 400 //	n yrs. last birt	thedread If I	Inder 1 Year	Potomac			gomery			
Funeral Director		DM ODE			nths Days		8. Date of Birth (Month, Day, Dec. 4,	^{Year)} 1931	Country) Washi	ngton, DC		
fand fan	10a. State 10b. County	10	c. City, Town	or Location	1		10d. Inside Ci					
Man Man	Maryland Montgo	mery	Potoma	ac					Yas 2□No			
er death with the Maryland herre 23e or 28e-f show one must be notified at Uneral Director	10e. Street and Number 7 Echo Court			10	f. Zip Code 208	54			g. Citizen of What Country? United States			
Dy P	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U,S.	10000	Decedent of I specify Cub es 2 1 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yas or No- Rican, atc.)	Black	- American k, Whita, atc. White			
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Bud be di	17. Father's Nama (First, Middle, Last) Abraham Jaff					18. Mother's Name Esther			a)			
Mar and 2 sh alth and 27 is m er treum	19a Informant's Name/Relationship (Ellen Jaffe/ Wi	•			dress (Street	Potomac			Stata, Zip Co	de)		
Baltimore, semit. Pages 1 a Department of He moortant: If them my injury or other Miss.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from Stata		y, crematory	or other pla	ce)	Date 9-30-99 Alexan	20c. Location - (-			
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30	30, Name and address of person who	completed cause of death	R	Type, Print	Be	thereto,	met.	2081	14			
State Registrar	31. Date filed (Month, Day, Year) OCT 1	32. Registrar	Signatura	19.	do	als						



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State of Maryland / Department of Health and Mental Hygiene o

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	23a. Pert1. Enter the disease, or compshock, or heart feilure. List	dications that caused the	death. Do no	30	Mac	e AVe. I	Baltimore	Md. 21	221	Approximete	
sician	shock, or heart feilure. List	one cause on each line.	7							Interval Between Onset and Deeth	
edical	Immediate Cause (Final disease or condition	CARI	DIAG	AR	2RE	ST				30 Mils	
iner	resulting in death)		to (or as a co	nsequence o	ŋ:					7110	1.1
nine		BEND 5	TAGE	P	EMA	L D	1 SEASR		3	MONTHS	
es the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enfer Underlying Cause (Disease or injury that initieted events	Due	to (or as a co	nsequence o	n):						
Cal	Ceuse (Disease or injury that initiated events	C. Due	to (or as a co	nsequence d	D:						
0 =	resulting in death) Last	d	10 (01 45 4 50		,						
cian	Dod II Ohan in Managaria					1	l an mil		1		
ached	Part II. Other significant conditions co	intributing to death but no	ot resulting in t	he underlying	cause give	en in Part I.	23b. Did 1			the cause of death?	
by P							-	22(110	00,100	25, 4, 5, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	
director, page 2 should be detached for use To Be Completed by Physician/N							24a. Wes perfo	an autopsy med?	ava	ore eutopsy findings uitable prior to upletion of cause death?	
omo							101	es at No		Yes 2□ No	
dor. p	25. Wes case referred to medical					26. Place of D	eath (Check only o	ne)			
To E	examiner? 1 Yes 22 No	Hospitel: 1 Inpatient	2□ ER/Outp	atient 3 1		4 LI Nursing	Home 5 ☐ Resid	lence 6 Oth	er (Specify)	
ation:	27. Manger of Death 1 A Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Ye	ar) 28b. Tir	ne of ury M	28c. Injun Work	yat (? Yes 2 □ No	28d. Describe t	ow injury occurr	red		
Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, fam pecify)	n, street, fect	ory, office	1	28f. Location (S City or Tox	Street end Numb in, State)	er or Aura	l Route Number,	•
dical (29a. Certifier (Check only one) 1 Certifying Phy	reician: To the best of my iner: On the basis of exa and manner stated.	mination and/	death occurre or investigation	d et the tim on, in my op	e, date and place pinion, death occ	ce, end due to the curred et the time,	cause(s) end ma date end plece, o	nner es st and due to	ated. the cause(s)	
To the Funeral Director: After this certificate has been signed by the ettendin completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/N	29b. Signeture and title of certifier	10			9c. License			29d. Date signed			
	· K. WILLOW V	W W			20	# 181	338	OCTOBI	EL 9	7, 1999	
- 1	30. Name and address of person who o	ompleted cause of death	(Item 23a) (T	ype, Print)	,	, , ,	338 C. BAC		-1 1	1	
		TERINO 9	1000 F	RAPRI	-IL.	SQ DE	2. BAC	-TOLP	0 2	11237	
State	31. Dete filed (Month, Day, Year)	32 Registrar's	Signatura							•	



Examiner Records. P.O. Box 68760.

physician end the buriel-transit law requires that the death certificate be executed 88 signed by the e been si s certificate has Jhe L Division of Vital or Attending Physician: director, this funeral After deeth. ofter deeth Director: A in 24 hour.
the Funeral Direction Hospital within 24 ho To the Fune completely f the th

Physician

/Medical

Examiner

Funeral

Director

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than "netural", or items 23s or the Medical Examiner must be r

r is marked other traumatic event, t

Important: If It any injury or o

Physician /Medical

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Certification: To

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25. Was casa rafarrad to medical Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Panding 1 Yas Invastigation 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifier

29b. Signeture and title of certifian 29c. Licansa number Carlas alexander mo

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)
CARLA 5. ALEXANOEK, MO 29 SGreene St Suite 300 Balt. Not 20201

State Registrar 31. Deta filed (Month, Dey, Year)

1 3 1999

32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

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29d. Data signed (Month, Day, Year)

OCTOBER 09, 1999

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/Medica Examine	4n English Mann (to			m <i>ber</i>)				4b. City, To	own, or L	ocation of Deat	4c. Count	ty of Death		
		. PULASK	I ST.					BAL	TIMO	RE		N/A		
Funeral Director	5. Social Security No. 215-36-42	1	ex ⊠M 2□F	7. Age (In yrs.	last birthday) If Under Months	1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Data of Bir (Month, Da Jan. 6,	iy, Year)		placa (Stata or Foreign htty) York	
9	Usual Rasidence of	Decedant												
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the M 28a-f notiffs	Maryland 10e. Street and Num	N/A		Ba	ltimo	10f. Zip	Code				ster/2			
6 6 8						101. Zip		01000			10g. Citizen of What Country?			
death ms 23	507 S. Pu	ilaski St			C 100	21223						J.S.A.		
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5-00		15. Decedent's Edity only highast ara	lucation		16a. Dec	edent's Usua	el Occup	etion	of af word	kina	16b. Kind of	Business/Inc	dustry	
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	23a. Part1. Entar th	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.										Taryla	Approximata	
Physician	shock, or haar	t failura. List only									Intarval Between Onset and Death			
/Medical	Immediata Causa (I	inal	Andre	miogala		Candi	i ~	1-			1			
Examiner	diseasa or condition resulting in death)	1	a. ALLE	erioscle	r as e conse			SCULA	E DI	sease		1		
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Ing Ing	27. Mennar of Death	5 Pending		of fnjury th, Day Year)	28b. Tima Injury		28c. Inju	ryat rk? Yes 2.∐	No	∠80. D&SCRID®	how Injury occi	nii ea		
Signature of the state of the s	2 Accident 3 Suicide	Investigation		of laine. As a	oma fac-	M tract factor		162 5	INO	28f Location	Street and Al-	her or Du-	al Routa Number,	
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State Registrar

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29b. Signature and title of certified

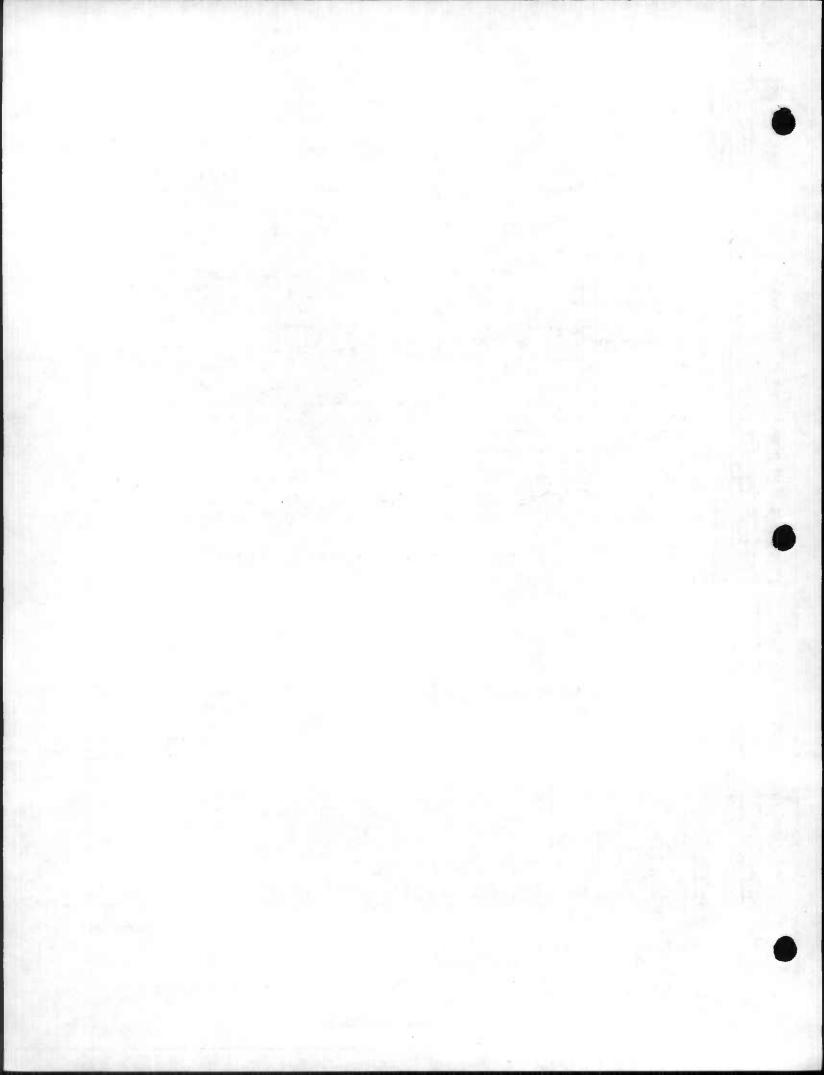
32. Registrar's Signatura

Drewa G. Sparks

of person who completed causa of death (Item 23e) (Type, Print)

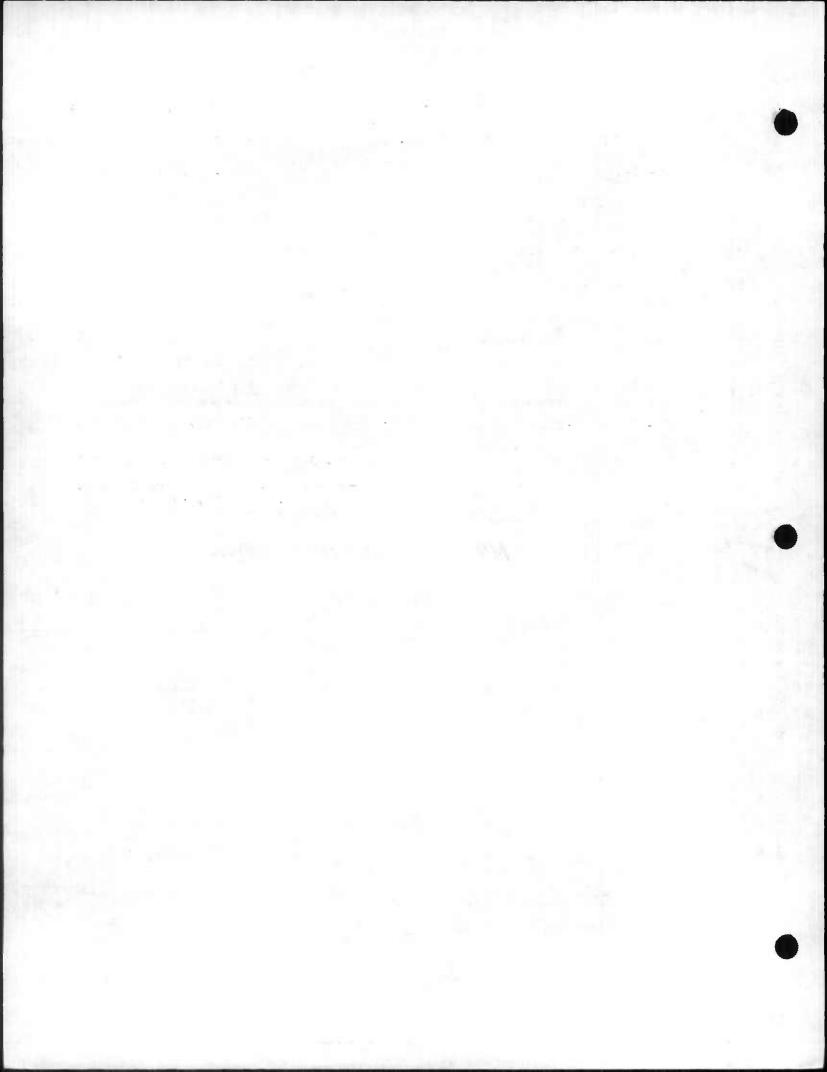
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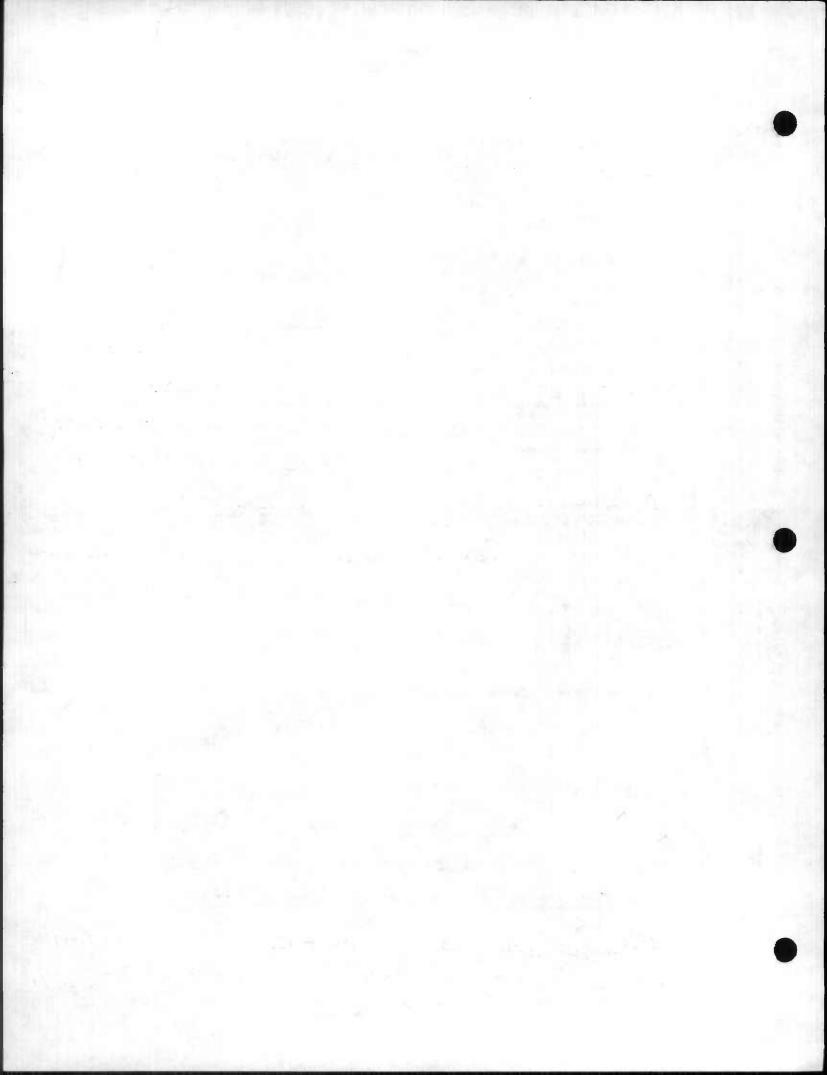
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Physician	Decedent's Name (First, Middla, Last	Chester	A.	Lemme		2. Deta of Death Month	Day Y	еаг	na of Death	
/Medical Examiner	de Espire Nove (Managination of		. A.	Бенше	4h Cib. Town or	October	-		:57 AM	
	Johns Hopkins Bayview Medical Ctr. Baltimo. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs.				-					
Funeral Director	5. Social Security Number 218-03-2103 Control of Sex 1 M 2 F									
h the Maryland r 28a-1 show undiffied at frector				Town or Location Harbor View			10d. Inside City Limits 1 ☐ Yas 2 No			
8 11 2	Maryland Ba 10e. Street and Number	ILIMOTE		10f. Zip C			g. Citizen of Wh	at Country?		
5 0M O	548 South 48th Street			21224			United States			
of 2 should be lied within 72 hours after death with and Mental Hygeria. Institutely, or learne 23s trainmaft's event, the Medical Examiner must To Be Completed by Funeral	11. Marital Status 1 □ Never Merried 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1Yes _ 2XNo If Yas, Give Yaar or Datas:		S. 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F			or No- c.) 14. Race - American Indian, Black, Whita, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed)		16a	16a. Decedent's Usual Occupation (Giva kind of work dona during most of workin lifa. DO NOT use retired)			16b. Kind of Businass/Industry			
	Elementary/Secondary (0-12)	College (1-4or 5	DRIEGE (1-40r 5+)				General Motors			
Hydier of Cor	12 Years				Security Patrol		Corp.			
S S S S S S S S S S S S S S S S S S S	17. Father's Name (First, Middla, Last)			18. Mother's Neme (First, Mide			fle, Maiden Sumeme)			
should ashould marks umarks	Antonio Lemme			Mary Marchesiana				na		
S a s a s a s a s a s a s a s a s a s a	WILC					Rural Route Number, City or Town, Stete, Zip Code)				
	Mrs. Gladys E. I	emme		18 S. 48th		altimore,				
S S S S S S S S S S S S S S S S S S S	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removel from State	20b. Place o cemate	Disposition (Nama ry, crematory or other	of r place)	Data 2	20c. Location - Ci	ty or Town, Sta	te	
permit. Pages 1 at Department of Hea Important: if Item 1 any Injury or other once.	4 □ Donation 5 □ Other (Specify		Meado	owridge Me	m. Park 10	/12/99	Dorsey	, Maryl	and	
	21. Signature of Funaral Service Licensee 22. Nama and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc.									
	23a. Part1. Entar the disease, or compshock, or heart feilura. List only			7922 7	lise Ave.	Dundalk,	Maryland	d 2122		
Medical Examiner Liansit Examiner Examiner	Immediata Cause (Finel diseasa or condition rasulting in death)	b	Due to (or as a	consequence of):	INFAME	NOW		8 8 9 6		
ng physicia as the bu	Sequentially list conditions, if any, leading to immediate cause. Enlar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): Due to (or as e consequence of):									
death cert e attendin ad for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given				e siven in Pert I	23b. Did tobacco use contribute to the cause of death				
hat the detached by the detached Physics	Taken, other eigenhouse continuous g to could but not los			uning at the unconyary cause given at Fatt.			1 Yes 2 No 3 Probably 4 Unknown			
							autopsy	24b. Wera auto	prior to	
law requires that as been signed as 2 should be delipieted by P						24a. Was ar perform		available p completion of death?	1 01 04000	
he law requents been age 2 should bringlete						24a. Was ar perform	ned?	completion		
he law requents been age 2 should bringlete	25. Was case referred to medical				26. Place of De	perform	s 2 No	completion of death?		
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Hospital or Attanding Physician: The law required to 24 hours after death. In 24 hours after death. The this certificate has been pletely filled in by the funeral director, page 2 should calcal Certification: To Be Complete.	examiner? 1	28a. Date of Injur (Month, Day) 28a. Place of Injur building, atc	y Year) 28b. (ny - At homa, fa (Specify) I my knowledge examination an	Time of njury M 28c njury M , death occurred at d/or invastigation, in	Other: 4 Nursing Halipury at Work? 1 Yes 2 No Notice	perform 1	s 2 No a) nce 6 Other w injury occurred reet and Number , Stata) suse(s) and mann tala end place, and	completion of death? 1 Yas (Specify) or Rural Route har es stated. d dua to the car	2 No Number,	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Dev **Physician** CHRISTINE GRACE MASON October 11, 1999 2:00pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Green Bank Road 13204 East Beach **Baltimore** Oliver 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthpleca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Deys 1 M 2 S→F Hours 49 Director 217-54-3354 24,1949 Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 28a-1 show must be notified at 1 Yes 2 No Director Maryland Baltimore 01iver Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð "natural", or flams 23s U.S.A. Funeral 13204 East Green Bank Road 21220-1166 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. filed within 72 hours after 1- Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2♥ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Chef years permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important! I flem 27 is married offles any Injury or other tree. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be 2 Earl Ulitt Mason Virginia Lillian Hewitt 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Virginia L. Mason / mother 13204 East Green Bank Rd. Balto, MD 21220-1166 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremetion 3 Removal from Stete Metro Crematory Inc. 10/12/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Fecility 21. Signeture of Funeral Service License Connelly Funeral Home Of Essex 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List prity one cause on each line. 21221 Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel ervical 12 months diseese or condition resulting in deeth) Cancer Examiner Due to (or es a consequença of) Examine physician and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or es a consequence of): 88 180 ò Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the signed by ti 1 Yee 2 No 3 Probably Unknown by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen s completion of cause of death? page 2 has 22 No 1 Yes 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ^o 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death Certification: 28b. Time of 28c. Injury et Work? 28d, Describe how injury occurred 5 Pending investigation 1 Weturel within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Cartifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10/12/1999 D417 12 MD xward 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAWANN L. TUNBUS, ND, PHIPS 248, 600 N. WOLFE ST, BAUTIMONE Mis 212 87 32. Registrer's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 0300 1999 Ernest William Meyer Oct 08 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deet Baltimore Deaton Specialty Hospital & Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | SEP 4, 1905 Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 1**X** M 2□ F Months 94 Yrs. Maryland 218-18-2591 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore MD N/A 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21230 600 Light Street, Apt. 922 USA 12. Was Dacedent Evar in U,S. Armed Forces? 1 ₹ Yas 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Merchant Marine Commercia1 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Dora Bach Gustav Meyer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 600 Light St., Apt. 921 Baltimore, MD 21230 Ida Daniels/Friend 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Buriai 2 IX Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/9/99 Baltimore, MD 4 Donetion 5 Dothar (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility Cremation Society of MD, Inc. MD 21228 299 Frederick Road Edward A. regorchik Baltimore, 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart Failure 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Damentil 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2⊅No 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the ceuse(s) and manner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licansa number 29d. Date signed (Month, Day, Year)

the death certificate be axecuted Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show odicsi Examiner must be notified at

Funeral

py

Completed

permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Haath, end Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examinar mass.

Physician /Medical

Examiner

physician a

80 9SN Examiner

Physician/Medical

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Certification: To

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Attending Physician: or Al 24 hours efter Funeral Dire lataly filled in b To the Hosp within 24 ho To the Fune complately fi

Registrar

31. Date filed (Month, Dey, Yeer) OCT 1 3 1999

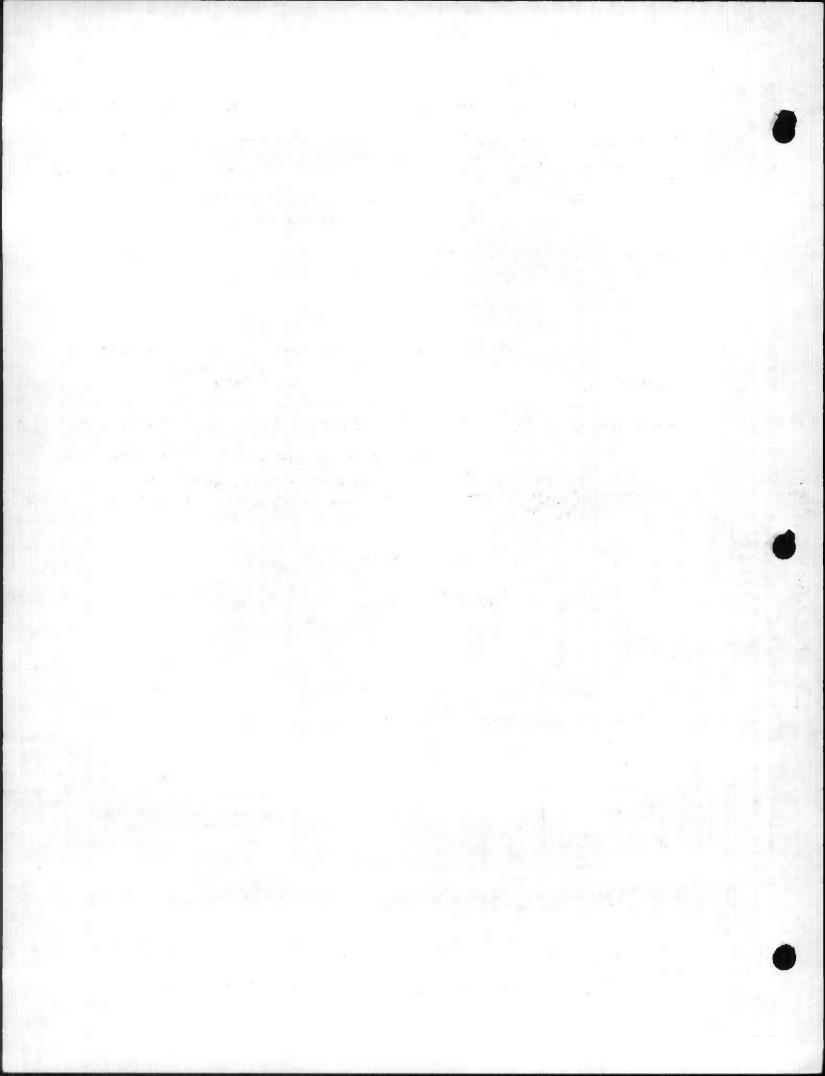
29b. Signature and title of certifier

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Haroves Jorbh

32, Registrar's Signeture

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State Registrar 30. Nat

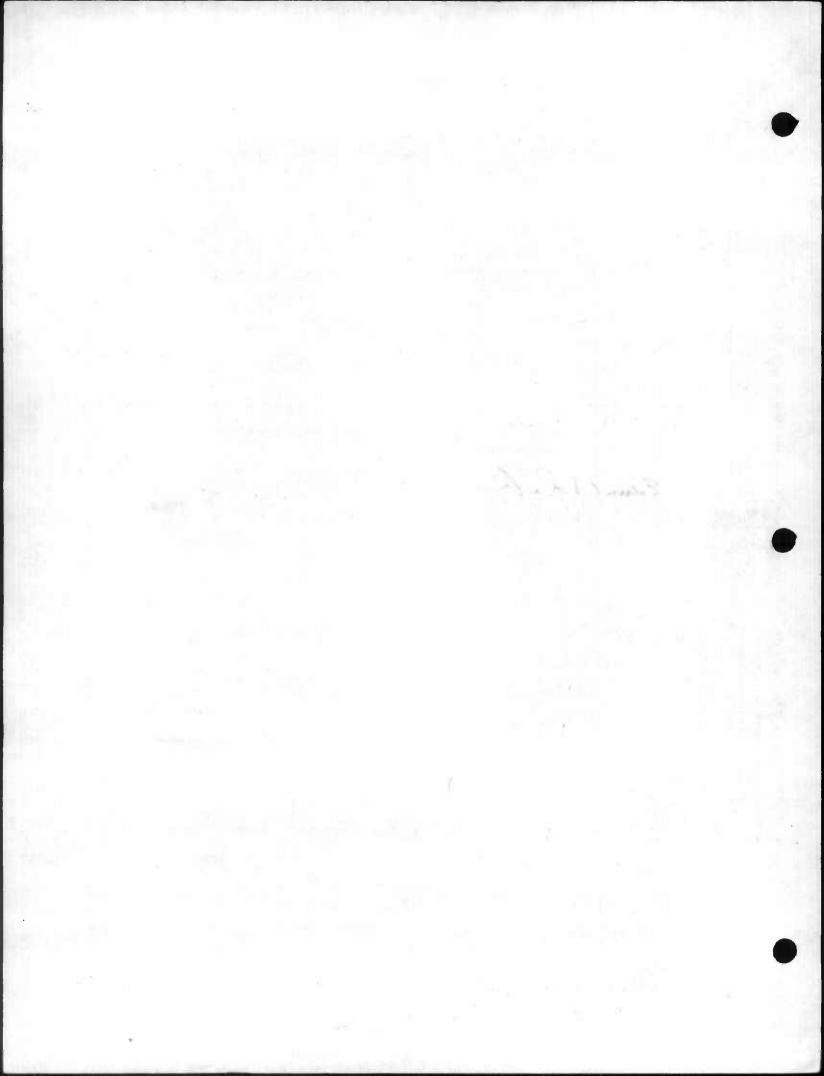
31. Date filed (Month, Dey, Year)
OCT 1 3 199

32. Registrar's Signeture

s of person who completed cause of deeth (Item 23a) (Type, Print)

B. Sparks

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

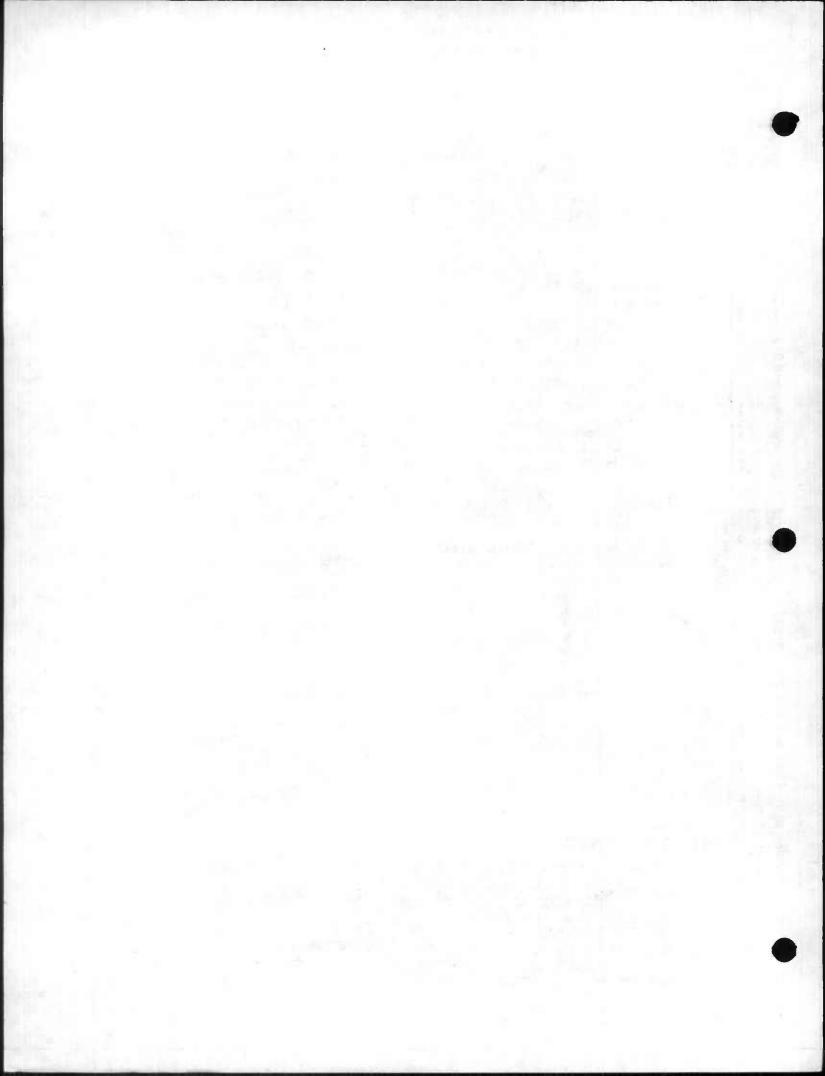
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Day Month Year **Physician** NICHOLAS MANNONE OCTOBER 6, 1999 07:57 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** Days 16M 20 F Months Hours 78 Yrs. 215-14-0331 8/19/21 Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location t Od. Inside City Limits 28a-f ahow r than "natural", or items 23s or 28s-f ahor the Medical Examiner must be notified at MD BALTIMORE RELAY 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Streel and Number 10g. Citizen of What Country? with 1705 ARLINGTON AVE. 21227 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces?
1 EVes 2 □ No It Yes, Give Year or Date 1:943 - 46 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Heelth and Mentel Hygiene. Important: if item 27 is marked other than "natural", or her any injury or other traumatic avent, the Heid self Examine Back. Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 College (1-4or 5+) WESTINGHOUSE INSPECTOR 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be GAPARE MANNONE ROSALIE BUCCHERI 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 1705 ARLINGTON AVE. BALTO., MD. MRS. JUDITH MANNONE 21227 20b. Place of Disposition (Name of cametery, cremetory or other place) Dete 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) GREEN MOUNT CEME. 10/9/99 BALTO., MD. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility KACZOROWSKI FUNERAL HOME P.A. Jacrowski 1201 DUNDALK AVE. BALTIMORE, 21222 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** ACUTE STROKE /Medical Immediete Cause (Finel 2 DAYS disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner physician and the buriel-transit be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) 980 P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown bengis be det Records, þ 24b. Were autopsy lindings available prior to Completed 24e. Wes en autopsy completion of cause of death? page 2 1 Yas 2 No 1 ☐ Yas 2 No certificate Division of Vital or Attanding Physician: director. 25. Was case referred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1.2 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 1 Neturel 5 Pending s after des. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, streel, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edical 1 Certifying Physician: To the best of my line
2 Medicat Examinar. On the lessis of examinar. 29e. Certifier et the time, date and place, end due to the cause(s) and manner as stated. dge, de (Check only one) On the basis of examination and and manner stated. in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29b. Signeture end titte of certifie 29c. License number 29d. Date signed (Month, Day, Year) 42736 30. Name and address of person, who cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 AYMAN AKKAD, M.O. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

OCT 13



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant'e Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** MIMS 1999 IRA 5:30 Det /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE BALTIMORE If Undar 1 Yaar if Undar 24 Hrs. 5. Sociel Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 12/31/1936 PENNSYLVANIA 9. Birthplace (State or Foreign **Funeral** 18 M 2□ F Months Days Hours 249-52-5931 62 Director Usuel Rasidance of Decedant death with the Maryland 10a. Stata 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ¥Yes 2 No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Cifizan of Whal Country? 6011 CHINQUAPIN PARKWAY 21239 USA 12. Was Decedani Evar in U,S. Armed Forcas? 1 ☐ Yes ≥ 2 ☑ No If Yes, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. flied within 72 hours eftar 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada completed) Hygiane. Elementary/Secondary (0-12) Collaga (1-4or 5+) 12YRS PLANT MANAGER MANAGEMENT Pagas 1 and 2 should be filed value of Health and Mantal Hygient: If Item 27 is marked other t 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) JAMES W. HILLS DELORES B. 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MARLAND MIMS (WIFE) 6011 CHINQUAPIN PARKWAY BALTO., MD. 21239. other 20b. Place of Disposition (Nama of cemetery, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 6 1 Burlal 2 ☐ Cramation 3 ☐ Removei from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Othar (Specify) MORELAND MEM. PARK 10/15/99 BALTO., MD. 21. Signeture of Funarai Sarvice Licensee 22. Name end Address of Fecility 23a. Pert1. Enter the disease, or complications thet caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onsat and Death **Physiclan** /Medical Immadiate Ceuse (Final 3-5 doys disaasa or condition rasulting in deeth) SEPSIS Examiner Due to (or es e consaquance of): Examiner Days PNEUMONIA physician and s the burial-transit Sequentially list conditions, if any, laading to Immadiata ceusa. Enter Underlying Causa (Disease or Injury Ihat initiated events rasulting in daath) Last Dua to (or as a consequence of): Y ears Box 68760, STAGE END 8 RENAL DISEASE Physician/Medical Dua to (or as a consequence of): 80 attending I for use es signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should should 24b. Wera autopsy findings eveilabla prior to completion of ceuse of death? 24a. Was an autopsy parformed? Completed hes cartificate 1 Yas 2 No 1 Yes 2 No Division of Vital Mospital or Attending Physician:
 24 hours efter deeth.
 Funeral Director: After this cartifice Be 25. Was cesa refarred to medicel 26. Place of Deeth (Check only one) axaminar? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Supatiant 2 ER/Outpetient 3 DOA funarai 28e. Data of Injury (Month, Day Yaar) 27. Mannar of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1-E Natural 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accident To the Hospital or Atter within 24 hours efter dat To the Funeral Director completely filled in by th 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29b. Signatura and litla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) MD P11902 Dan Oct 11, 1999

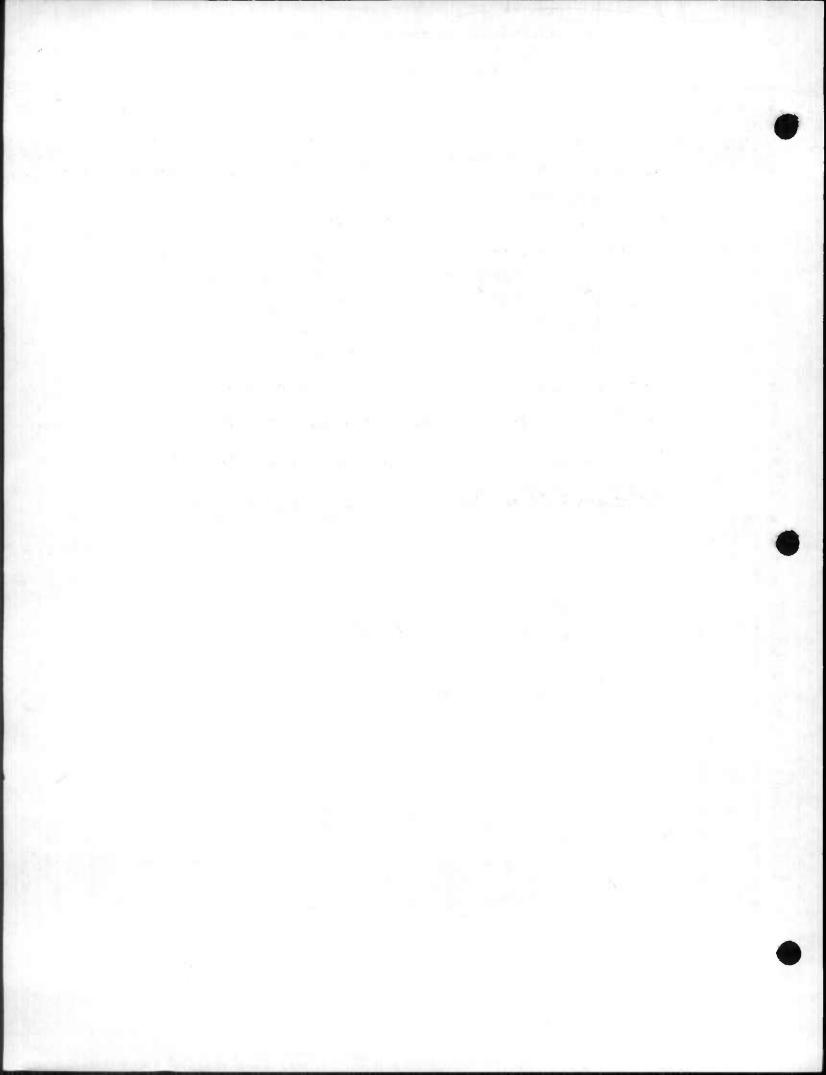
Registrar

31. Date filad (Month, Day, Year) OCT 13 1999

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 600D SAMARITAN HOUP, TAL NOUHAD DAMAT

BALTIMORE MO 21239 32 Registrer's Signatura

Darks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1105Pm JAMES DAUID 10 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Village Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Months 1 M 2 F Yrs 215-10-4328 June 18, 1914 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Baltimore Maryland Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd. 21234-9033 U.S.A. Apt. 4219 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: ₩₩ II 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner of Colony Press 12 yrs. Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henrietta Laupheimer George Raymond Marks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mrs. Katherine V. Marks / Wife 8820 Walther Blvd. Apt. 4219 Baltimore, Md. 21234 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State h Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 10/14/99 Pikesville, Maryland 21. Signature of Furniral Service Licery 22. Neme end Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 an 23a Fart. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List cony one cause of stack line. Approximete tnterval Between Onset end Death Immediate Cause (Final 1997 disease or condition resulting In death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ement 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 1 Delatural 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

Examiner physician and s the burial-transit be axec Box 68760. Physician/Medical P.O. been signed by should be detac þ Records, Completed Division of Vitai Be edical Certification: To this

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or itema 23a or 28a-f show adical Examiner must be notified at

death

filed within 72 hours after

Pages 1 and 2 should be nent of Heelth and Mental

permit. Pages 1 and 2 a Department of Heelth ar Important: If Item 27 Ia any Injury or other trau

Physician /Medical

Examiner

aitimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

P

Attending Physician: hours after death. ð To the Hospital or within 24 hours aft To the Funeral Di completely filled in

31. Date filed (Month, Day, Year) Registrar

2 Accident

3 SuicIde

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

walther 8800

29c. License number

112 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

1 Yes 2 No

29d. Date signed (Month, Day, Year) 11

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

5 Pending

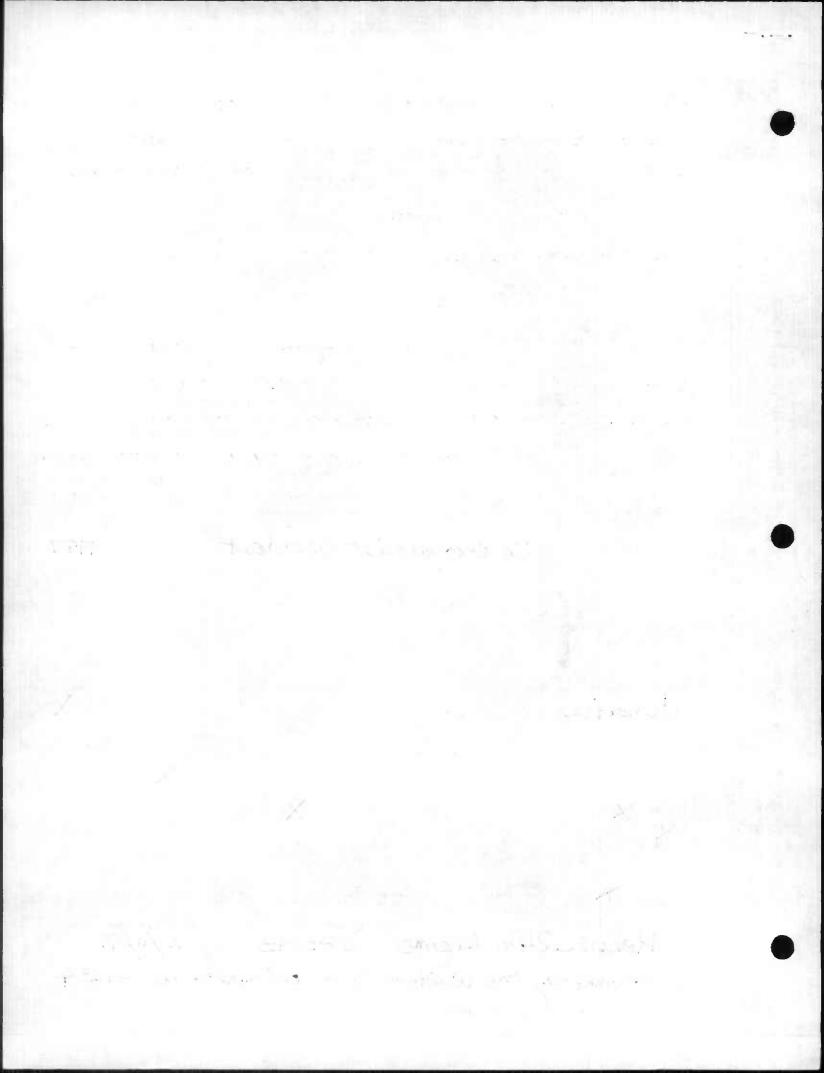
investigation

6 Could not be determined

Baltimore MD Blud

32. Registrer's Signature OCT 13 1999

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)



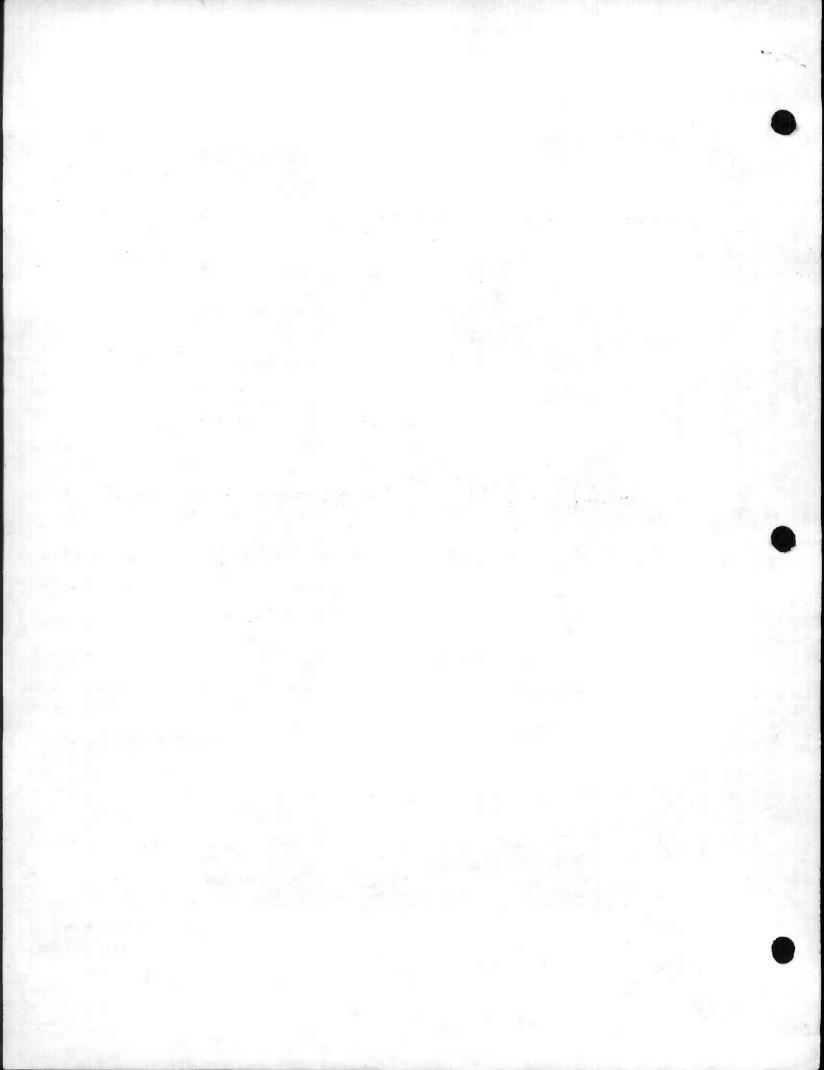
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Mulhall 10:30 pm OCTOBER 09 James 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Bunn balt mire Resimal Center Bay view N/A 8. Data of Birth (Month, Day, Year) If Under 24 Hrs. 5. Social Sacurity Number 6. Sex If Under 1 Year 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Months Days Hours Yrs. 233-56-2358 Director July 26, 1938 Pennsylvania 61 Usual Rasidance of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits ahow rai", or items 23a or 28a-f ahov Examiner must be notified at 1 Yes 2 No Director Pennsylvania Franklin Fayetteville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? P.O. Box 89 17222 United States Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel hygiene. Important: if item 27 la marked other than "natural", or hen any Injury or other traumatic event, tra Medical Examinations. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Industrial Manufacturing Estimator 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be 2 James J. Mulhall Myrtle L. Wallace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda V. Mulhall/ Wife P.O. Box 89 Fayetteville, Pennsylvania, 17222 20b. Place of Disposition (Name of cometery crematory or other place Heffner Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Crematory, Inc. 10/11/99 York, Pennsylvania 21. Signature of Funaral Service Licensee Milton, J Knight Jr Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximata Interval Between Onset and Deatl **Physician** Multiple System /Medical Immediata Causa (Final disaasa or condition rasulting in death) 6 days tay we Examiner THE APPROVED BY DEDUCE TRANSPER Examiner degree skin burn sicien end burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of): irrhosis physicien s the buria Box 68760. Physician/Medical Due to (or as a consequence of) Hewte P.O. 23b. Did tobecco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate hes t lirector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case refarred to medical examinar?
1 2 Yas 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 15 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Injury 1 Natural 5 Pending October 03, 1949 4 pm M 10

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) death. 1 Yes 2 No backyart Gurning 2 Accidant investigation leaves in e Hospital or Attending to Automate the Funeral Director: / 3 ☐ Suicida 6 Could not be detarmined 281. Location Street and Number or Rural Route Number. City or Town State) 4 Homicida PO 804 Home edicai 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mariner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number AT24389 46-NUI October 09 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Bouview Regional Center 4940 Easton Avenue, Bultmicre, MD STEVER LAUZON

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32: Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** Augusta Pearl Manns October 6, 1999 9:35p.m. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye Birthplace (State or Foreign Country) **Funeral** Hours 1□ M 200 61 213-36-3161 Director Nov. 28, 1937 NC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md. Baltimore 1 Xes 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2830 Clifton Avenue 21216 USA 13. Wea Decedent of Hispanic Origin? (Specify Yea or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14 Race - American Indian 11 Marital Status Bleck, White, etc. 'natural', or Itan dical Examiner 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: Black by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Dye Cutter Lion Brothers 11th Grade Pages 1 and 2 should be filed nent of Health and Mental Hygi ant; If Ilem 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 89 John McMillan Foddie Mae Price 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2830 Clifton Avenue Baltimore, Md. 21216 Geraldine Taylor daughter important: If Isam 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 DBGrial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Arbutus Memorial Park Oct. 11 Baltimore, Md. 22. Name and Address of Fecility 21. Signature of Funerel Service License Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Pert1. Enter the disease, or complications that o'u ed the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on a a line. Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) YEAVS Examiner Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) physician s the burial Box 68760. Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vitai or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 | Nursing Home 5 | Residence 6 (Mother (Specify) 1405 pice Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Neturat 5 Pending investigation death. 1 Tyes 2 □ No e Hospital or Attandi 24 hours after death e Funeral Director: / 2 Accident 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. within 2 \$

State Registrar

31. Date filed (Month, Day, Year) OCT 13 1999

30. Name and address of person who completed tause of death (from 23a) (Type, Print)

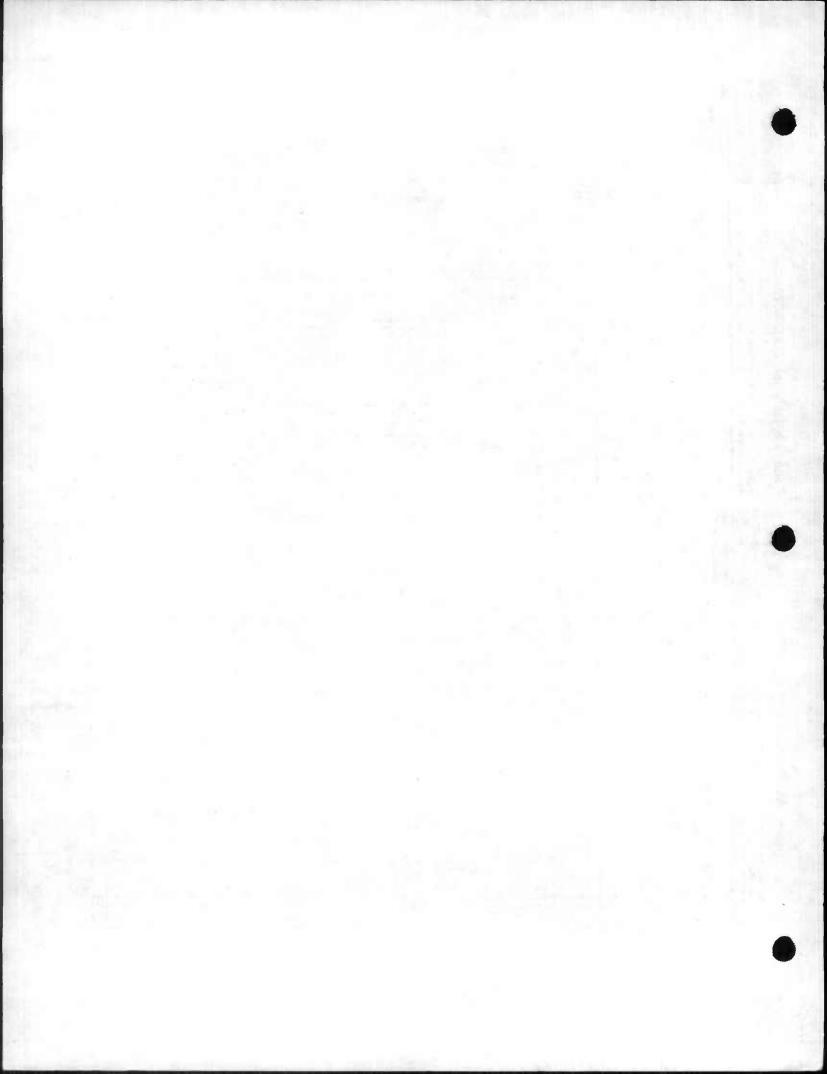
29b. Signeture end title of certifipe

6-Bmc 32 Aegistrar's Signature N. Charles St. Balto. Md Zizas

29c. License number

29d. Date signed (Month, Dey, Year)

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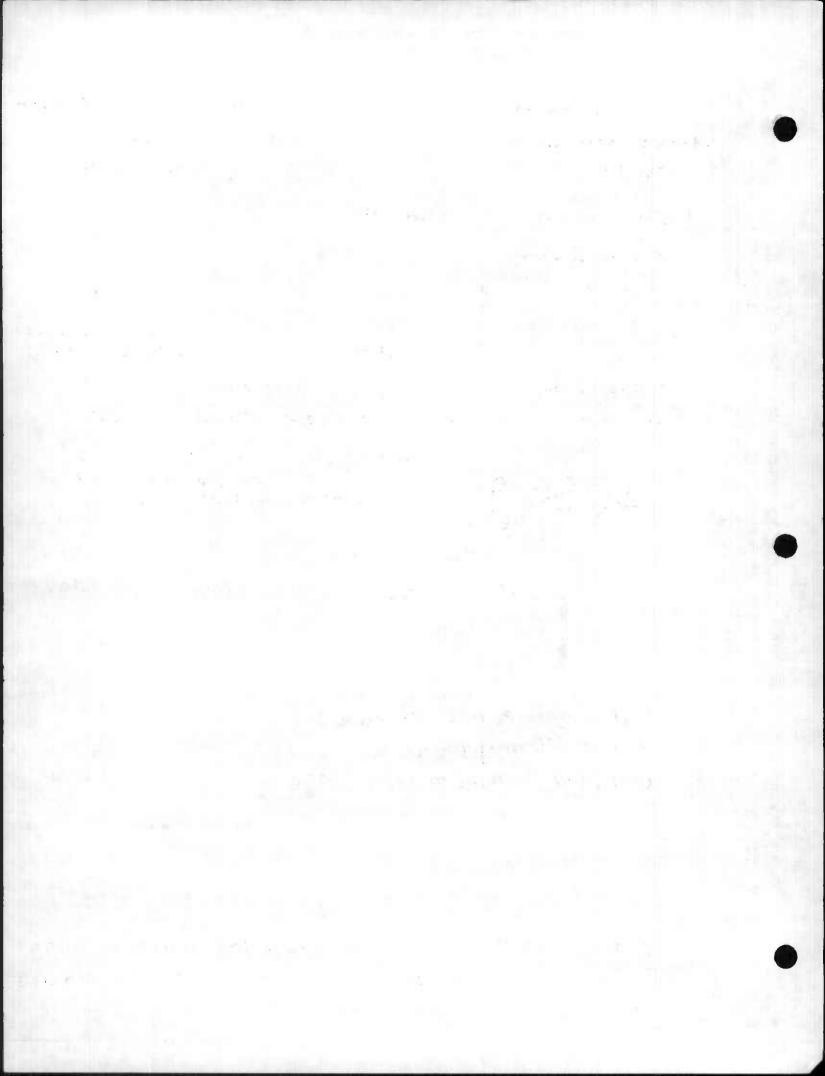


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 3192

Certificate of Death Reg. No.

Physician Medical Examiner Part Physician Physi			Certificate of Death	Reg. No.	31921	
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Physician Medical Examiner 23a. Part I. Enter the dhease, or completations tifal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate interval Between Cheek and Death of the Completation of	Pa Pa	1 X Burlal 2 Cremation 3 Bemoval from Stata cemete	ery, cremetory or other piece)	Ct. 13		
Physician Medical Examiner Physician Medical Examiner Physician Medic	Balt permit. Depart Import any inj once.	21. Signature of Funeral Service County	30			
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25. Was case referred to medical examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homloide 4 Homlo	The I he ste he sage	Immuno Combromi	red stage	1□ Yes 2⊠No	1 ☐ Yes 2 ☒ Ño	
Second of the control of the contr	ita milio	25 Was case referred to medical		n (Check only one)		
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3 2 a Cartifler 15 Cartifular Physician. To the best of my knowledge death occurred at the time date and place and due to the cause/s) and manner as stated	Divis lor Atter effer des Director d in by th	3 Suicida 6 Could not ba determined 28e. Place of Injury - At home, f building, etc. (Specify)	larm, street, factory, office	28f. Location (Street and Number or City or Town, Stete)	Rural Route Number,	
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)	To the		29c. License number	29d. Date signed (Mc	onth, Dey, Year)	
AT 2438-946 October 10, 190		Kuthelinav, mD	AT 2438	746 october	10,1999	
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Rajiv Thankar Union Memorial hoespital, Beikiman, MD2	5	30. Name and address of person who completed cause of deeth (Item 23a) Rativ That Kay Union 7) (Type, Print)			
State Registrar 31. Data filed (Month, Dey, Yeer) A2. Registrar's Signature ACT 1 3 1999		31. Data filled (Month, Dey, Yeer) 82. Registrar's Signatury	. Sparks			

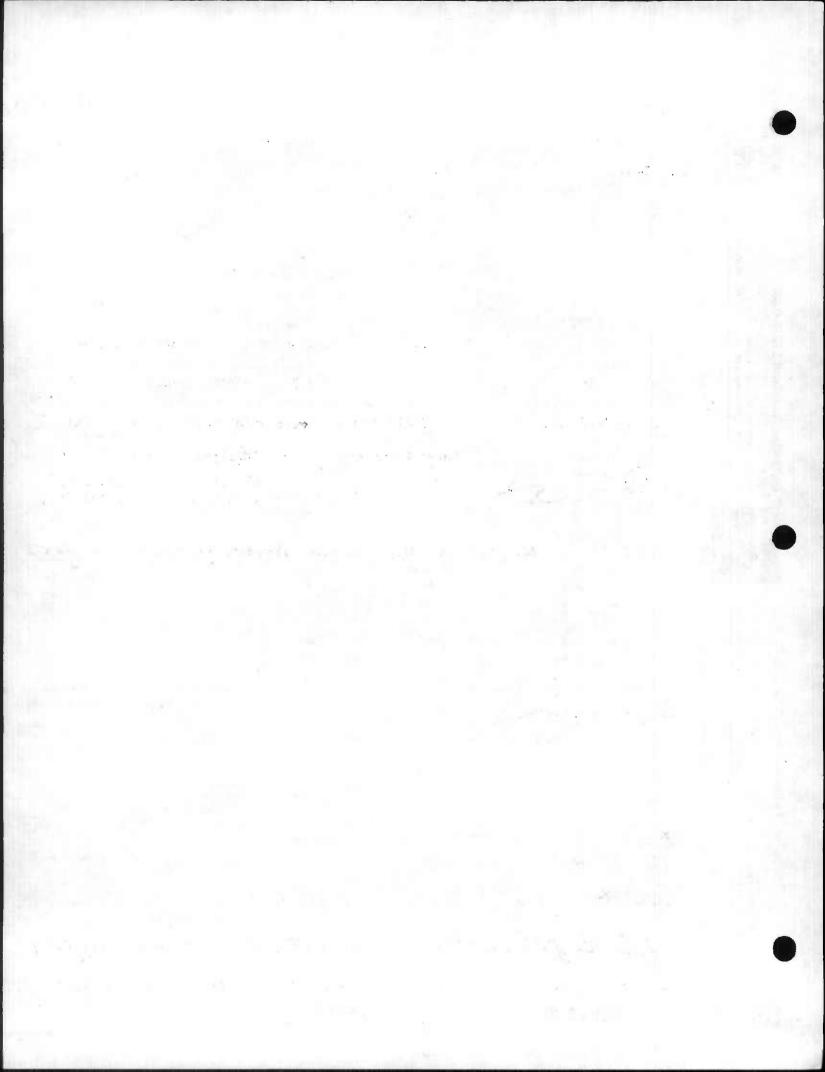


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 3192

		Certificate of Death	Reg. No.							
	Decedent's Name (First, Middla, Last)	2. Date Mor	a of Death 3. Tima of Death							
Physician /Medical	Agnes Owens		ober 8, 1999 10:00 PW							
Examiner	4a Fecility Name (If not institution, giva street and number)	4b. City, Town, or Location of								
Funeral Director	6138 Parkway Drive	Baltimore	N/A							
	5. Social Security Number 6. Sex 1 M 2C F 7. Aga (In yrs. In 215-09-5442	Months Days Hours Min. (Mo	a of Birth north, Day, Year) 9. Birthplaca (Stata or Foraign Country) Maryland							
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	10e. Street and Number 6138 Parkway Drive	10f. Zip Code 21212	10g. Citizen of What Country? U.S.A.							
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72 hours "netural",	15. Decedant's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry							
	(Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5+)	(Give kind of work dona during most of working lifa. DO NOT use relired) Data Entry/ Instructor	Federal Reserve							
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pemit. Pag Department Important: I eny injury o	21. Signature of Funaral Sarvice Licencee		rd Funeral Home, Inc. altimore, Maryland 21229							
	23a. Part 1. Enter the diseasa, or complications that caused the death shock, or heart failure. List only one cause on each line.									
Physician	shock, or haart failure. List only one cause on each line.		Intarval Between Onset and Deeth							
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Examiner		Abdominal Aortic	Analysis 2 glor 3							
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ficate be experience of the burie	that initiated avants									
deeth certificate be executed the attending physician and set for use as the buriel-transit sician/Medical Examir	resulting in death) Last Due to (or as a consequence of):									
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at the deeth celetached by the attendiretached for use	Part il. Other significant conditions contributing to death but not rasu	iting in the underlying cause given in Part I.	b). Did tobacco use contribute to the cause of death?							
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has the possion mpi			of daeth?							
			1 Yas 2 No							
Physician: The ribis certificate ral director, per ral director, p	25. Was casa rafarred to medical examiner?	26. Place of Death (Chec	k only one)							
the season in			Residence 6 □Other (Specify)							
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DIVISION C be or Attending P is after death. el Director: After t ed in by the funera Certification:	3 ☐ Sulcide 6 ☐ Could not be detarmined 28a. Placa of Injury - At hon building, atc. (Specify,		cation (Street and Number or Rural Routa Number, y or Town, Stata)							
Hospi 24 hou Funer tely fill	29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinating and mannar stated.	viedge, death occurred at tha tima, data and place, and dua ion end/or investigation, in my opinion, death occurred at th	to the cause(s) and manner as stated. te time, data and place, and due to the ceuse(s)							
within 2 To the comple	29b. Signature and title of certifiar	29c. License number	29d. Deta signed (Month, Day, Year)							
	1 Sen E John My	D 19558	October 11, 1999							
	30. Name and addrass of person who completed cause of death (Item									
0	Dr. Glen Johnson 716 Maiden Ch 31. Deta filed (Month, Day, Year) 32. Registrar's Signat		imore, Maryland 21229							
State Registrar	OCT 13 1999	G. sparks								

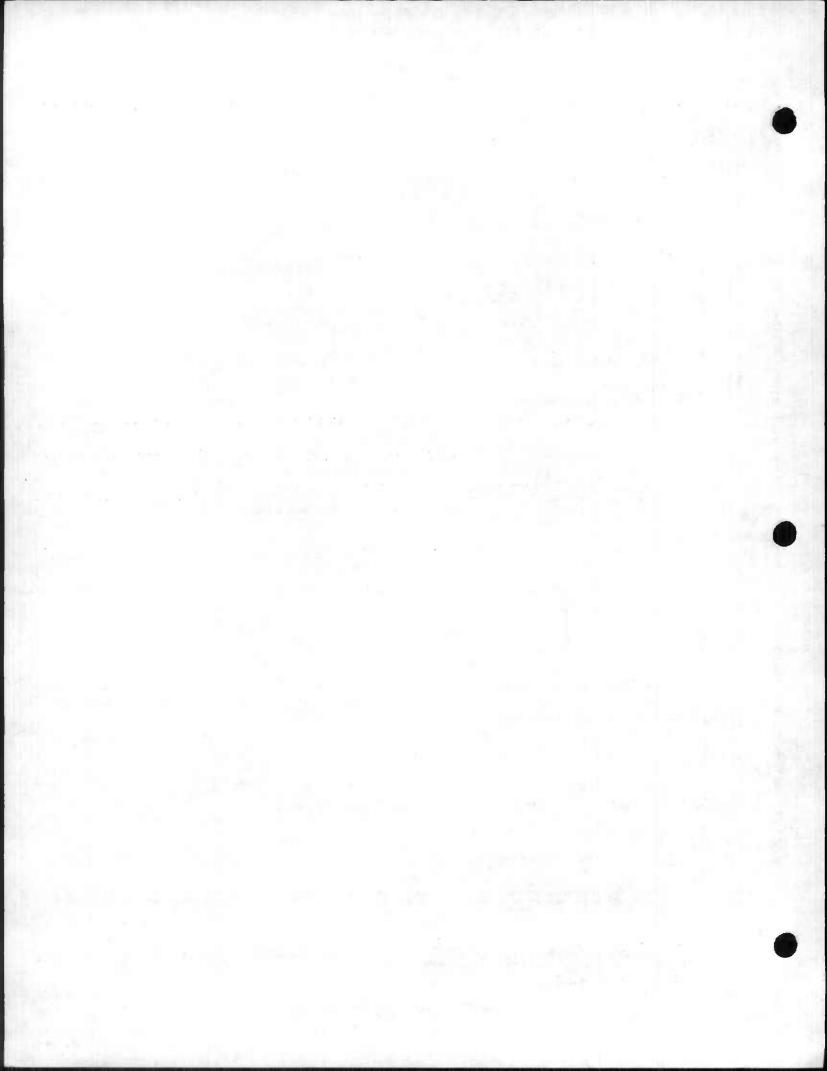
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				iaiyiaiid / i	Certificate o		Re	g. No.) (31923
Die	inian	1. Decedent's Neme (First, Middle, Last)				2. Dete of Death Month	Day	Year	3. Time of Death	
200	ysician Andinal	Martha V. K. Pl:	itt				October	9, 199		4:30 PM
E10	Medical aminer	An English None (Mark Institution also standard and an experience			4b. City, Town, or L		4c. County			
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	to a	Maryland n/a		Baltime	re					1 X Yes 2 □ No
	be notified Director	10e. Street and Number		Duzuzu	10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?
	1 0	2222 Dishmond A			21212			TICA		
a 2	era e	3332 Richmond Av	12. Was Deceden	t Ever in II S	21213	f Hispanic Origin? (Sr		USA 14 Bac	e - Americ	an Indian,
21215-0020 d within 72 hours after d giene. or than "natural", or feer	Examinar must by Funeral	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas	? No	If Yes, specify Co	f Hispanic Origin? (Spuban, Mexican, Puerto o Specify:	Rican, etc.)		k, White,	
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d 212	f O	17. Father's Name (First, Middle, La		1101	Hellakel	18. Mother's Nem	e (First, Middle, M			
Maryland 212. d 2 should be filed within th end Mental Hygiene. 7 le marked other than	Se e					1.100			,	
aryla should and Men	월	Samuel Kunz				Martha I				
Sar Sar	L.	19e. Informent's Neme/Reletionship	(Type, Print)	19b	. Meiling Address (Stre	et and Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
CEN	4	Nancy A. Packard	1 / Daughte	er 1.	514 Hollins	Street, 1	Baltimore	, Mary	land	21223
	retto	20a. Method of Disposition		comete	Disposition (Name of ry, crematory or other p	(ace)	Dete 2	Oc. Location -	City or To	own, Stete
	7 04	1 Surial 2 □ Cremetion 3 4 □ Denation 5 □ Other (Spe		8	n Park Ceme		10/13/00	Doltin	ore	Maryland
The F	=	21. Signature o Funarel Service Lic		Loudo	22. Neme end Add		10/13/99	Daiti	ore,	Maryrand
Baltimore, permit. Pages 1 at Department of Heal Important: If Nem.	once	P R Sinding of Grand Service En	L.			Funeral Hor kens Avenu	me, Inc.	nore. M	larv1	and 21229
/Med Exami	ner o	Immediate Cause (Final disease or condition resulting in death)	e	Due to (or as e	consequence of: heart consequence of:	Faclyre			1	
. Box 68760, death certificate be executed e attending physician and	etached for use as the burial-to Physician/Medical Exe	Sequentially list conditions, if any, leading to immadieta cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c		consequence of):	#1				
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O the off	detached	Pert II. Other significant conditions	contributing to death	but not resulting ii	the underlying cause	given in Pert I.				
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Div To the Hospital or I within 24 hours after To the Funeral Dire	edical (of examination an	, death occurred et the d/or investigation, in m					
0 40	W W	29b. Signatura and title of certifier			29c. Lice	nse number	29	d. Date signe	d (Month,	Day, Year)
FSF	0	1 /1	,		no	2726	1	7. 4 10	10	9 0
		Ihh th	my		WS	2137	0	ct 13	19	(]
		30. Name and address of person wh		death (Item 23a)	(Type, Print)	MJ 2122	0			
	State	31. Dete filed (Month, Day, Year)	32 Regis	trar's Signeture	. Spark				-	
He	gistrar	OCT 1 3 19	77	/	1					

946



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth PINKNEY MILTON **Physician** JOHN /Medical 1999 October 11 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Greater Baltimore Medical Center Towson
If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Dey, Year) 9. Birthplece (State or For Country)
Apr. 27, 1931 Mary Area Sex M 2□ F If Under 1 Year Funeral 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Deys Hours Min 212-18-5/01 78 Director Usual Residence of Decedent 10e. Stete 10h County na 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits BALHNORE Tes 2 No Funeral Director TULUSON Mary mo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? BOSIEY AVENUE 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 ≥ Yes 2 □ No WWI 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Americen Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 No by 3 ☐ Widowed Divorced Specify: Black Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CHAUKER 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Peges 1 and 2 should be filed with nent of Health and Mental Hygiene. 8 4 9 7 de 17. Fether's Name (First, Middle, Lest BIVE SHEILD of Health and ...
If item 27 is marked our.
-her traumatic event, IIV 18. Mother's Neme (First, Middle, Maiden Sumeme) JOHN M. Pinknoy FTOYENCE 19e. Informent's Name/Reletionship (Type 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mack Kinkney 728 BOSLEY lowson, marylono 21204 20c. Location - City or Town, Stete 20e. Method of Disposition 10/15/99 Burial 2 Cremation 3 Removal from State = 6 nt REN Come to 10/15/47 10

22. Name and Address of Facility CILLA TMAN- H
5340 RUSTENETOWN RUAN
BOTTONE, MA 212/5 10 Cosm 4 □ Donetion 5 □ Other (Specify) 21. Signature of Fungral Service Lighnage 23a. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** RESPIRATORY Immediate Ceuse (Final FAILURE disease or condition resulting in deeth) PNE UMONIA Physician/Medical Examiner Sequentielly list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest 68760. Due to (or as a consequence of): Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? RENAL DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown STAGE Records, 24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? HYPER TENSION) 1 ☐ Yes 1 ☐ Yes 2 ☐ No Vital 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 SInpatient 2 □ ER/Outpatient 3 □ DOA of 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Division or Attending 5 Pending Investigation 1 Neturel To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde Medicai 29a. Certifier 15 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 47051 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) N. CHARLES ST #216 BALT. MD 21204 S. ALMARID 6565 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

14046

Registrar

OCT 13 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔘 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Victor Harriman Poole October . 5:45 AM 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Blakehurst Retirement Community Towson Baltimore Co. If Undar 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Sacurity Number 8. Dete of Birth (Month, Dey, Yeer) November 03,1918 Baltimore, Maryland 7. Aga (In yrs. lest birthdey) 8. Dete of Birth (Month, Dev. 1**K**1M 2□ F 212-18-0908 Yrs. 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 No Maryland Baltimore Co. Towson 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1055 West Joppa Road Apt. 532 21204 United States of America 12. Was Decedant Ever in U,S. Armed Forces? 1 M Yas 2 □ No W.W.II If Yes, Give Yaar or Dates:1941-1945 14. Raca - American Indian, Black, White, atc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 1 Never Married 2 X Married 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Spacify only highest greda completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) J.E. Greiner Co. 12 04 Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Ralph A. Poole Helen V. Richardson 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mrs. Virginia Lee(nee Brown)Poole(Wife) 1055 West Joppa Road Apt.532 Towson, Maryland 21204 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 【Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corporation 10/12/1999 Towson, Maryland 21. Signature of Tuneral Service Licensee Jeffrey L 22. Name and Addrass of Facility Ruck Towson Funeral Home, Inc. nir 1050 York Rd. Towson, Md. 21204 ar(1/Enter the disease of complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, tonly one cause on mach line. Approximate Interval Ret Interval Between Onset and Deeth a. Gastis intestinal himserhage - upper Immediate Cause (Final 1 hc. disease or condition resulting in death) Presund Bleeding leptic We-Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death?

Physician /Medical **Examiner** Records, P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Exercines must be notified at

Funeral Director

Completed by

Be

death with the Maryland

filed within 72 hours after

parmit. Pages 1 and 2 should be filed within 7: Department of Heelih and Mental Hygiene. Important: If Itam 27 is marked other than "ne any Injury or other traumatic event, me Mental Once.

21215-0020

Baltimore, Maryland

the buriel-trensit or Attanding Physician: After

in by the funeral within 24 hours after death. To the Funeral Director: A completely filled in by the fu the Hospital

Division of Vital

Physician/Medical Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Anterioretentia Contionarenten disens: Peripheral Cerebaverella Be Completed Gangrans fort when states port gight above knee ampletion Multi-inferet dementie; Chronic Ronal Insufficiency 25. Was case referred to medical 28. Piace of Death (Check only ona) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No 27. Mannar of Death 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and manner steted. Medicai 29a, Certifier

1 ☐ Yes 2 🗖 No 1 ☐ Yes 2 No 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State)

29b. Signatur	ra and title of	Pertifiar			
	04/	11	(1)	.\/.	
	0//	U.	UU	~	13

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Oct 12 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAYMOND W. WILSON MD. 6565 N. Charles A. Smite 416, Baltimore, MD., 21204

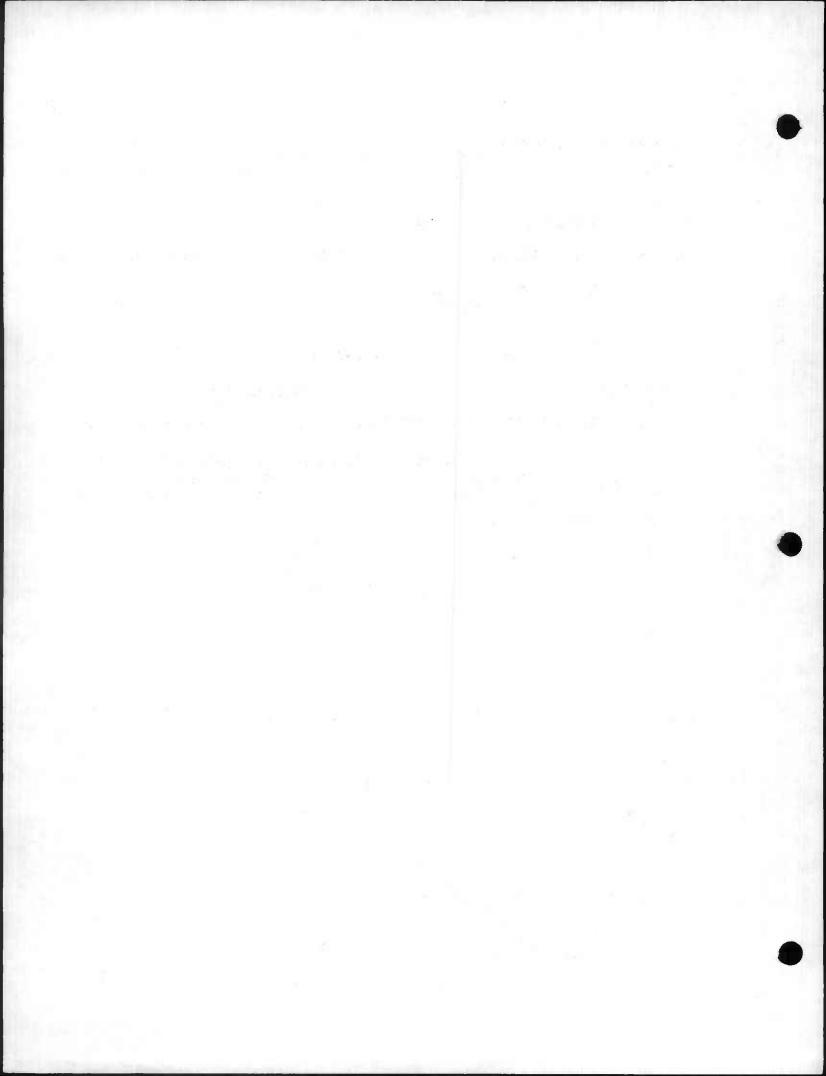
a filed (Month, Day, Year)

32. Registrar's Signature

B. Spouls

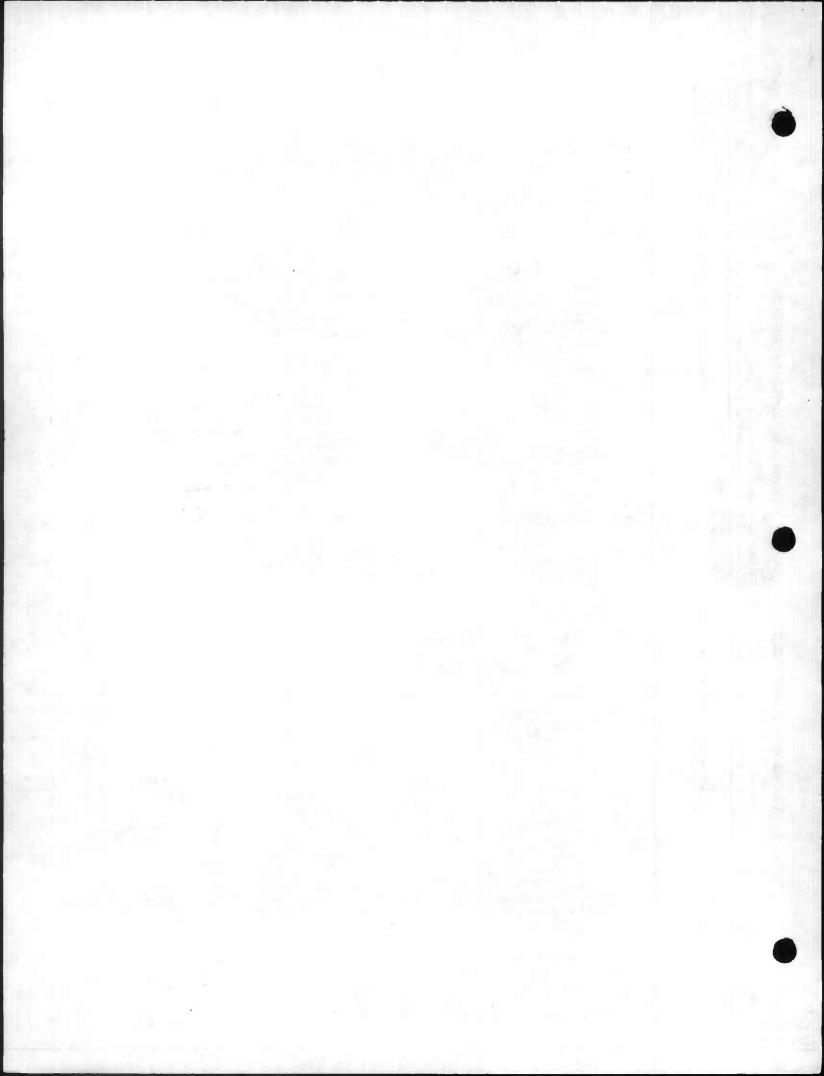
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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			o mary and	Certificate of Death	Reg. No.	31926	
	Physician	Decedent's Nama (First, Middla, Last)	-	P	2. Date of Death Month Day	3. Tima of Death	
	/Medical	Patricia	t.	Pierce	October 11	1999 15:49	
	Examiner	4a Facility Nama (If not Institution, give street an	d number)	4b. City, Town, or L	0'11	if Death	
		5. Social Security Number 6. Sex	7. Age (In yrs last bit	thday If Under 1 Year If Under 24 Hrs.	8. Date of Bight	9. Birthplace (State or Foreign	
L	Funeral Director	212-36-5477 1 M 2 V		Yrs. Months Days Hours Min.	(Month, Day, Year) JAN. 15,1938	Country) MARYLAND	
	Sand Sand	10a. Stata 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits	
020 urs after death with the Maryla it, or thems 23e or 28e-f show Canniner must be notified at	Man Had	MARYLAND N/A	BAI	TIMORE CITY		1. Yas 2 No	
	or zla-f a be notified Director	10e. Street and Number		10f. Zip Code	10g. Citizen of W	hat Country?	
		159 N. CURLEY STRE	ET	21224	U.S.A		
	D 2.4 5	1 Nevar Married 2 Married 1 1	Decedent Evar in U,S. od Forces? Yas 27 No s, Giva or Datas:	13. Was Decedent of Hispanic Origin? (Si if Yes, specify Cuban, Mexican, Puerto		- Amarican Indian, k, Whita, atc. FRO-AMERICAN	
2-0	72 ho natural Scal	15. Decedant's Education (Specify only highast grada comple	ted) 16a	Decedent's Usual Occupation (Giva kind of work dona during most of work	16b. Kind of Bus	sinass/Industry	
21215-0020	ed within 72 ho ygiene. wr then "natum 4, the Medical.] Completed		ge (1-4or 5+)	lifa. DO NOT use retired)			
	Co. Hand	10TH N/A	PF	RIVATE-DUTY NURSE		TH CARE	
pur	B sent	17. Father's Nama (First, Middla, Last) LEONARD J. DODD			na (First, Middle, Maiden Sumama	()	
SE SE	Merika Marka Marka To				L SMITH		
Maryland	d 2 st frame frame	19a. Informant's Name/Relationship (Type, Print, INGRAM SUGGS/DAUG		o. Mailing Addrass (Street and Number or Ru 9 N. CURLEY ST.			
	Heatt em 2 ther	20a. Mathod of Disposition	20b. Plece 0	Disposition (Nama of		City or Town, Stata	
altimore,	SE SE SE SE SE SE SE SE SE SE SE SE SE S	1₽Burial 2 ☐ Cremation 3 ☐ Ramoval f	rom Stata cemata	ry, crematory or othar piece)	CT. 18,1999 B		
Ē	arten a	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensea	DALII	22. Nama and Addrass of Facility	J1. 10,1999 B	ALIIMORE, MD.	
Ba	Dep Paris	14. 64		CALVIN B. SCRUGO	SS FUNERAL HO	ME	
		23a, Part 1. Enter the disease or complications t	hat caused the death. Do	1412 E. PRESTON	ST. BALTO, M	D 21213 Approximata	
	Physician	23a. Part1. Entar tha disaasa, or complications t shock, or haart failura. List only one cause	on aech lina.			Intarval Between Onset and Death	
	/Medical	Immediata Causa (Final	anctio	occlusion			
	Examiner	diseasa or condition rasulting in death) a.		consequence of):			
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	ificate be executed physician and as the burial-transit edical Examiner	Sequentially list conditions.	Dua to (or as a	consequence of):			
0,	ian a urial-t	Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disaase or injury c.					
68760,	ficate be physicial is the bur edical	that initiated events rasulting in death) Last	consequence of):				
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Box	thend or us	d					
	requires that the death certified seem signed by the attending hould be detached for use a tould by Physician/Me	Part ti. Other aignificant conditions contributing	to death but not resulting i	n the underlying causa given in Part I.	23b. Did tobacco use con	tribute to the cause of death?	
P.0	Ad by detac				1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown	
of Vital Records,	2 22 2				24a. Was an autopsy	24b. Were eutopsy findings	
00	been si should leted				performed?	available prior to completion of cause	
Rec	has has					of death?	
<u>a</u>	certificate ha rector, page Be Com				1 □ Yas 2 No	1 Yas 2 No	
=		25. Wes casa rafarred to medical examiner? 1 Yas 2 No Hospitel:		Other	th (Check only one)		
		27. Manner of Deeth 28a. D	1 Ninpatient 2 ER/Ou Data of Injury 28b.	Itpatient 3 DOA Work? Work?	oma 5 ☐ Rasidence 6 ☐ Otha 28d. Describe how injury occurre		
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á	tal or Attending P rs effer death. al Director: After t ied in by the funers Certification:	4 Homicide	ouilding, atc. (Specify)		City or Town, Stete)		
	4 hour funer lesky fill	(Check only 2 Medical Examiner: On the	o the best of my knowledge ha basis of axaminetion an mannar stated.	e, death occurred at the time, date end plece, d/or invastigation, in my opinion, deeth occu	end due to the cause(s) and mar red et the time, date end place, a	ner as stated. nd due to the cause(s)	
	within 2 To the comple	29b. Signstura and titla of certifier		29c. License number	29d. Date signed	(Month, Day, Year)	
		Kalul	OC	RES-001	o Octobe.	11 1999	
		30. Name and address of person who complated	causa of death (Item 23a)	(Type, Print)		21287	
		Jetray Halsell, Do	Johns Hor	Kins Hospital 6001	J Wolfe Street	Baltimore, MD	
	State		32. Registrar's Signatura	4 fords			
	Registrar	02T 1 3 1999	, per	s. japours			



cancer

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? Sano 1 ☐ Yes 1 Yes 2 No

25. Wes case referred to medical examiner? 1 Yes 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Deeth Natural
2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. tnjury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Cartifier (Check only one)

4 Homicide

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Completed

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Certification: To

edicai

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of

29c. License number D0054912 Dete signed (Month, Day, Year)

30. Name and address of person who completed pluse of death (ttem 23a) (Type, Print)

BROAD

BALTIM 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

Records,

Division of Vital or Attending Physician:

The law requires

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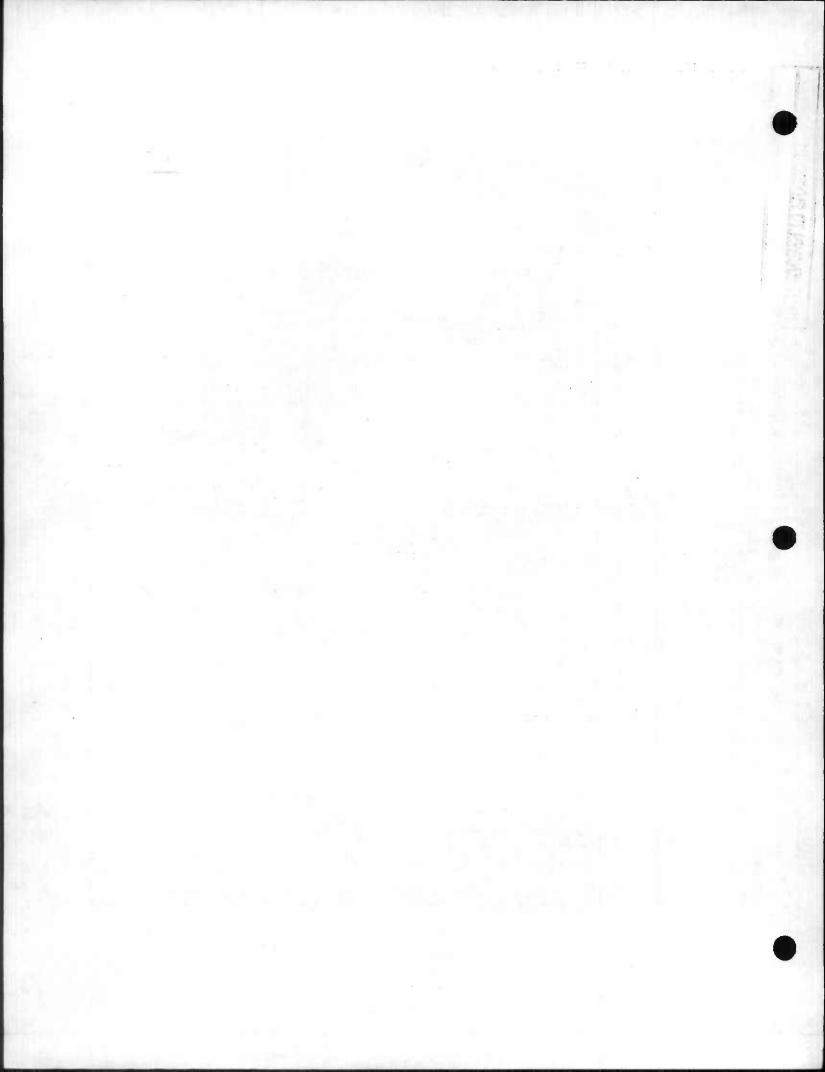
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e Hospital or Attending 24 hours after deeth.

within 2 To the \$



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month 3. Time of Deeth Vera A. Payton-El 4, 1999 4c. County of Death 4:50a.m. October 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 3306 N. Hilton Street Unit 101 Baltimore n/a If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) Days Hours 219-26-1270 10 M 20F 61 Dec. 13, 1937 Md. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits n/a Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3306 N. Hilton Street Unit 101 21216 USA 12. Was Decedant Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Detas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Elementary/Secondery (0-12) College (1-4or 5+) Administration Benefits Administration 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Nathaniel K. Brown Ida M. Hinkson 19a. Informent's Neme/Relationship (Type, Print) COUSIN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Hermione Graham 6011-3 Majors Lane Columbia, Md. 21048 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Arbutus Memorial Park Oct. 8 Baltimore, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service Licensee 2501 Gwynns Falls PKWY Baltimore, Md. rutter 23a. Pent1. Ehter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Deeth Panculatic tmmediete Cause (Final disease or condition resulting in deeth)

Physician /Medical Examiner

Department of Health and Important: If Item 27 is m any injury or other traum

Physician

/Medical

Examiner

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Funeral

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Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner and physician cata has been signed by page 2 should be detact Completed by Be Medical Certification: To this within 24 hours after death To the Funeral Director; / completely filled in by the

or Attending Physician: The law requires that the death certificate be executed

Hospital

within 2 To the

Division of Vital Records, P.O. Box 68760,

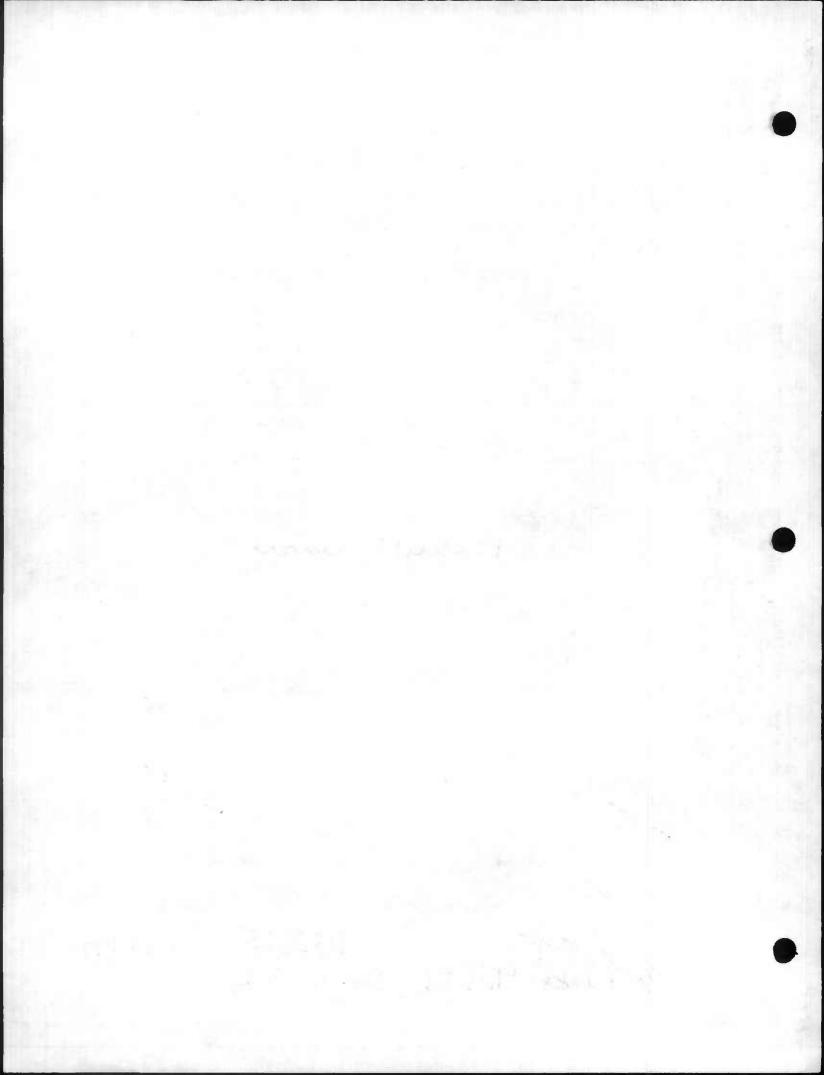
	_ \				
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due to	or es a consequence	of):		
Cause (Disease or Injury that initiated events resulting in death) Last	CDue to (or es a consequence o	n):		
Part II. Other significant condition	ds contributing to death but not re	sulting in the underlyin	g cause given in Part I.	23b. Did tobecco use co	ntribute to the cause of death?
				1□Yes 2D/No	3 Probably 4 Unknown
				24a. Was an eutopsy performed?	24b. Were eutopsy findings available prior to completion of causa of daath?
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examinar?	Hospital:	☐ ER/Outpatient 3☐	Other		ner (Specify)
27. Manner of Death 1 Netural 5 Pending 2 Accident investige	ition	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicida 6 Could no determir	28e. Piece of Injury - At I	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			per or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of my kn keminer: On the basis of examin and menner stated.	owledge, death occurr etion and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	e, and due to the cause(s) and ma surred at the time, date end placa,	anner as stated. and due to the cause(s)

State Registrar

31. Dete filed (Month, Day, Year) 13

29b. Signature end title of

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** POPE Month ANNI OCTOBER 1846 20 /Medical 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, pr Location of Deeth Examiner Ba amai Balti If Under 24 Hrs. rimore 5. Social Security Number 6. Sex 7. Age (In yrs. lest bilthday) Birthplace (State or Foreign Country) **Funeral** 215-30-5692 1□M 20 F Deys Director land Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mary land Director 1 Yes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 828 21225 permit. Peges 1 and 2 should be filed within 72 hours efter death will Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Modical Exercities must be pointe. ve. Funeral Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. - Hmerican þ 3 ☐ Widowed 4 ☐ Divorced HTTO Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden, Surname) Be 19a. Informant's Name/Reletionship (Type, Print) (Aguighter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stefe, Zip Code) d. 21206 TO, 20b. Plece of Disposition (Neme of conjectery) cremetory or other plece) 20a. Method of Disposition Dete 20c. Location -City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 13 22. Name and Address of Facility
JOSEPH L. RUSS
2222 W. North 21. Signature of Funeral Service Licenses tue Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Physician Immediete Cause (Finel 2 months disease or condition resulting in death) LUN G CANCER Due to (or as e consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contribute to the cause of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown þ Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical 28. Place of Death (Check only one) Hospital: 1 ⊠(Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Menner of Death Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide Medicai 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one)

The law requires that the death certificate be executed P.O. Box 68760, Records, of Vital or Attending Physician: Division death. within 24 hours after deat To the Funeral Director: completely filled in by the the Hospital

filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020

28a-f show

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the Medical Examiner must be notified at

State Registrar

SASKA 31. Date filed (Month, Dey, Year)
OCT. 1 3 1999

MONA

29b. Signature end title of certifier

5601 32. Registrar's Signature

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

2

WCH.

29c. License number

11390

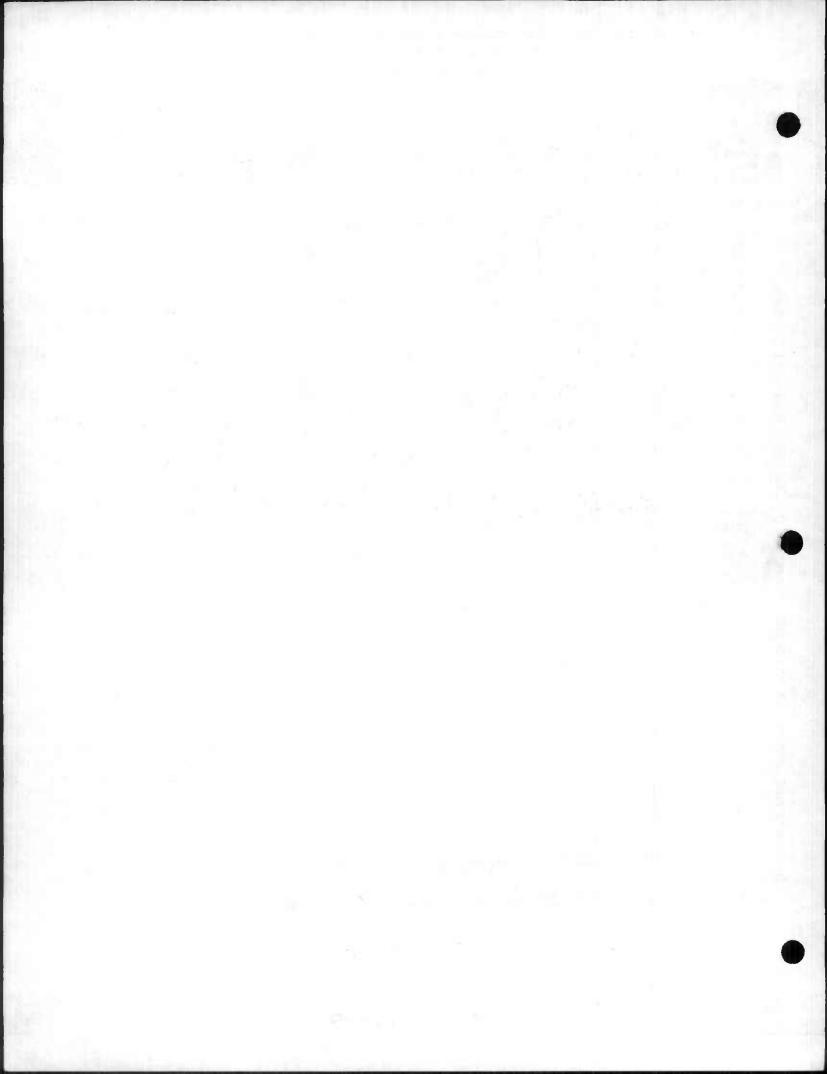
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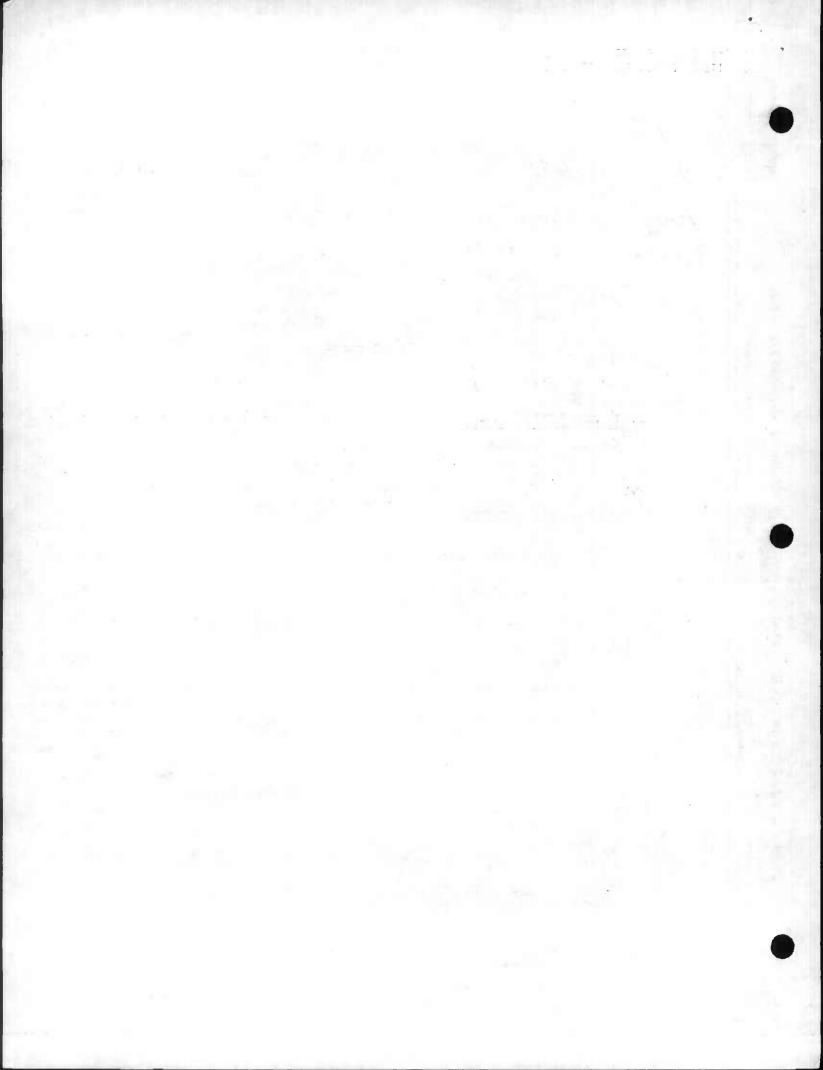
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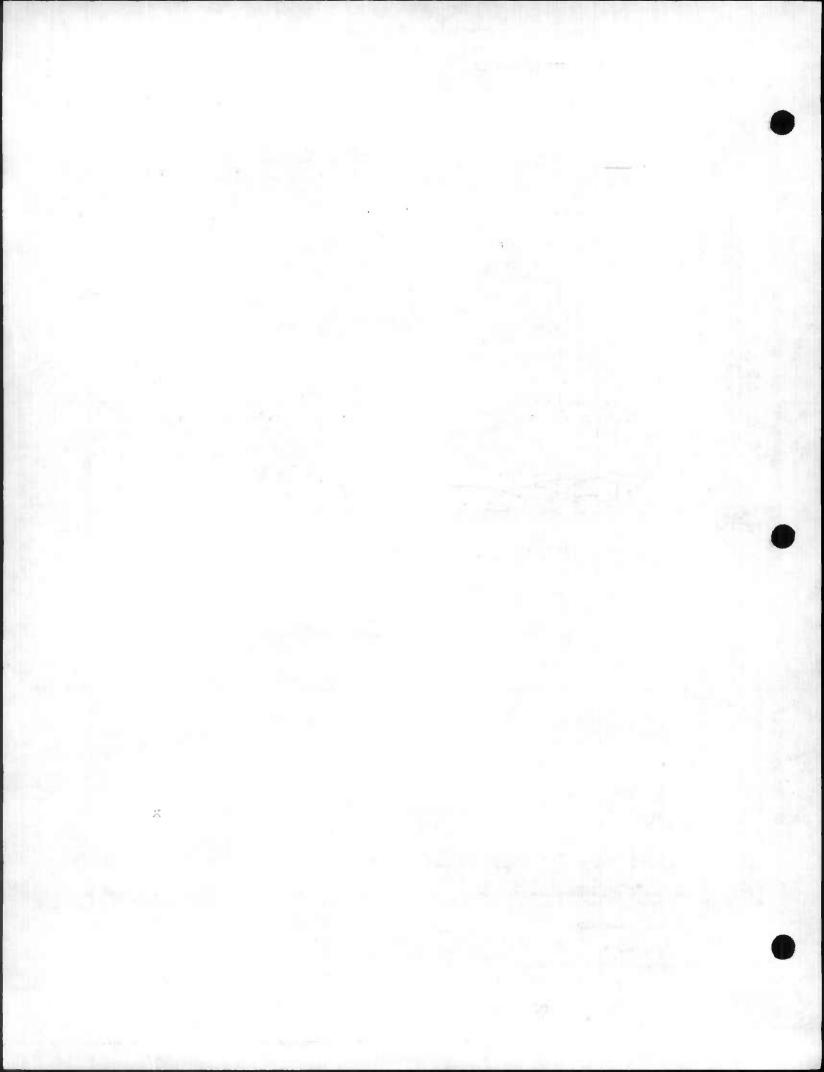


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item#19b perFH G776 10/20/99EW State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #19 PER F.H. G776 10-13-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** HAROLD RANDOLPH 16:20 CCTOBER 09 99 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nursing Boltinea LEUINDALE Home If Under 24 Hrs. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 63 26537 Director 36 MASS Usuel Residence of Decedant 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits •how r 28a-f show BALFINSK Yes 2 No Director Kary IAMA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8 WALBrook 21217 USA Norms 23a 12. Wes Decedent Ever in U.S. Armed Forces?
20 Yes 20 No / 956 If Yes, Give Yeer or Detes: / 96/ 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mentai Hygiene. Important: if Nem 27 is marked other than "natural", or Nem any Injury or other treumatic event, the Medical Experiment Black, White, of 1 Never Married 2 Married Black 1 Yes 2€ No Baltimore, Maryland 21215-0020 Specify Specify: à 3 Widowed Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Dlum BGR 12 46ARS 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) RAM OULDA, SR ROSE HARUCU Andrews 19e. Intormant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Longastaten oque, MY Sycuismeth CAMILLE 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetary, crematory or other) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel trom Stete
4 Donetion 5 Other (Specify) 22 Name and Address of Facility CIII TMBR- MI 52 40 Rei STERS found Runo Bolthhor, Ned 3-1215 ERP Hount 21. Signature of Funeral Service Licensee - HARKIS TUNA 23a. Part T. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical a ANOXIC ENCEPHALOPATHY Examiner 2 MONTHS Dua to (or as e consequence of). Physician/Medical Examiner VENTILATORY DEPENDENT 2 MONTHS physician and the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Dua to (or as a consequence of): 68760 C. CHRONIC YEARS CBSTRUCTIVE PLLMONARY DISEASE Due to (or es e consequence of): MONTHS Box CVA P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☑ No of Vital 25. Was case reterred to medical 26. Place of Deeth (Check only one) Hospitel: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Deeth 28d. Describe how injury occurred Division 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Routa Number, City or Town, State) 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicida Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the best of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mennar stated. (Check only one) 29c. License number 29b. Signeture end title of certifier 29d. Data signed (Month, Day, Year) Denna · Eversley D0054739 m.D OCTOBER 10th 1999 30. Neme and addrass of person who completed causa of deeth (Item 23a) (Type, Print) LEVINDALE GERIATRIC CENTER , 2434 W. BELVEDERE AVENUE , BALTIMORE MARYLAND 1999 82. Registrer's Signetury State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	AMEND #5 PER F.H. G777 11-4-99 J.A. Certificate of Death	Reg. No. 99	31931				
Physician /Medical	Towns D. Down	onth Day 1999 Ye	3. Time of Death 11:00 am				
Examiner	4a Facility Neme (If not institution, give street and number) 3709-A McDonogh Road 4b. City, Town, or Location Randallstow		timore				
Funeral Director	143-14-3633 3855 Maria - M	ate of Birth Month, Day, Year) ay 13, 1922	Birthplace (State or Foreign Country) VA				
r the Maryland	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location PA Chester West Grove		10d. Inside City Limits 10€ Yes 2 □ No				
fier death with the Marker death with the Marker rate to nodified the rate of the contract of	10a. Street and Number 264 West Evergreen Street 264 West Evergreen Street 107. Zip Code 19390 10g. Citizen of What Co						
d 21215-0020 Illed within 72 hours after death with the Maryland Hygiene. Inter then "natural", or Items 23s or 28s-1 show and, the Medical Examiner must be notified at the Completed by Funeral Director	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:		American Indian, White, etc. Black				
Baltimore, Maryiand 21215-0020 semit. Pegas 1 and 2 should be filed within 72 hours aft operation of of Heelih and Mental Hygiene. Important: if flem 27 is marked other than "natural", or my injury or other traumatic avent, the Medical Examinate. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) College (1-4or 5+) Laborer	16b. Kind of Busin					
Maryland 2121 42 should be filed within head Mental Hygies 7 is marked other than Traumatic avent, the Me To Be Comple	Phillip Roape Tulia	t, Middle, Maiden Sumame) (Unknown	Maiden Name)				
re, Maryis 1 and 2 should Heelth and Mer em 27 is marke other traumatic	19e. Informent's Neme/Reletionship (Type, Print) Nancy Colbert / Niece 19b. Mailing Address (Street and Number or Rural Road) 3709-A McDonogh Road, R						
imore, Pegas 1 an nent of Heel mit: If Item 2 Lry or other	20a. Method of Disposition 1		y or Town, State quare, PA				
Baltimol permit. Pegas Department of Important: If it any injury or o	21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore Maryland 21230						
Physician	23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respands, or heart tellure. List only one cause on each line.	piratory arrest,	Approximate Intervel Between Onset and Deeth				
/ /Medical Examiner	Immediate Cause (Final disease or condition resulting In death) Chronic Lung Disease		Years				
	Due to (or as a consequence of): Smoking		1				
rords, P.O. Box 68760, requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit eted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						
P.O. Box at the death certification of the attending etached for use a Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contri	bute to the cause of death?				
S, P.O as that the igned by th be detache by Phys		1/3/Yee 2□ No 3	□ Probably 4 □ Unknown				
2 × × ×		24a. Wes an autopsy performed?	4b. Were autopsy tindings available prior to completion of cause of death?				
= - 22 0		1 ☐ Yes 2 💢 No	1 ☐ Yes 2€ No				
On of aling Phys After this funeral di	27. Menner of Death 1 Neturel 5 Pending investigation 3 Suicide 6 Could not be determined. 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28d. 1	eck only one) 5 Residence 6 DOther (Describe how injury occurred ocation (Street and Number of Town, State)	11115				
Hospi 24 hour Funer tely fill	29e. Certifler (Check only only only only only only only only						
To the within 2 To the comple	29b. Signature and title of certifier Mark Cames MD 29c. License number D32453	29d. Date signed (A Octobe	Month, Day, Year) r 12, 1999				
	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Mark A. Lamos, MD 9 Schilling Road, Hunt Valle	y MD 21031					
State Registrar	31. Date filed (Month, Day, Year) OCT 13 1999 32. Registrar's Signature G. Locals						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death October 12, 1999 **Physician** Daniel Gaffney Rupert /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6018 Sefton Avenue Baltimore 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F If Under 24 Hrs. 8. Date of Birth 08/08/19/0 5. Social Security Number If Under 1 Yaar 9. Birthplaca (Stata or Foraign **Funeral** Hours Maryland 216-15-1275 Director Usual Rasidence of Decedent the Maryland 10c. City, Town or Location 10a. Stata 10b. County items 23s or 28s-f show the Medical Examiner must be notified at N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6018 Sefton Avenue 21214 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status filed within 72 hours after 1 Nevar Married 2 Married natural, or altimore, Maryland 21215-0020 1 Yes 2 No White Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Hyglene. Elemantary/Secondary (0-12) College (1-4or 5+) Electrician/Cable Splicer Electrical Janiel Rupert 17. Father's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be fi Department of Health and Mental H important: If fram 27 is marked oft any injury or other traumatic avan page. Be Pages 1 and 2 should be nant of Health and Mental William Grant Rupert Mary Eileen Walsh 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. Kathleen Rupert/Wife 6018 Sefton Avenue, Baltimore, Maryland 21214 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 Coremation 3 ☐ Removal from Stata Hilltop Service Corporation 10/15/99 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funaral Service Licensee Christina L. David

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

28b. Tima of

Melgnoma

metatatic

Physician /Medical Examiner

I.copm

66/8/101

physician and the burial-transit that the death certificate be asscuted signed by the a certificate has b this After death.

or Attending Physician: Hospital

Box 68760 P.O. Records, Division of Vital within 24 hours after death To the Funeral Director: , completely filled in by the To the within 2

Examiner Physician/Medical Be Completed by Medical Certification: To

State

Sequentially list conditions, if any, leeding to immediata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting In death) Last

Immediata Cause (Final

diseasa or condition rasulting in death)

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 25. Wes casa rafarred to medical 1 Yes 2 No 27. Manger of Death Nature 5 Pending invastigation 2 Accident 6 ☐ Could not be detarmined 3 ☐ Suicide 4 Homicide

29a. Cartifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end dua to tha cause(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifie

28a. Date of Injury (Month, Day Year)

29c. Licensa number MO 038409

28c. tnjury at Work?

1 Yas 2 No

5305 Harford Road, Baltimore, Maryland 21214

29d. Data signed (Month, Day, Year) 13/12/99

nd, 21093

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

Comprone

26. Place of Deeth (Check only one)

1 ☐ Yes 2 No

28d. Describe how injury occurred

3. Tima of Death

10d. Insida City Limits

Approximata Interval Batween Onset and Death

2 MONTHS

24b. Ware autopsy findings available prior to completion of cause of death?

20 No

1 Yas 2 No

1:00AM

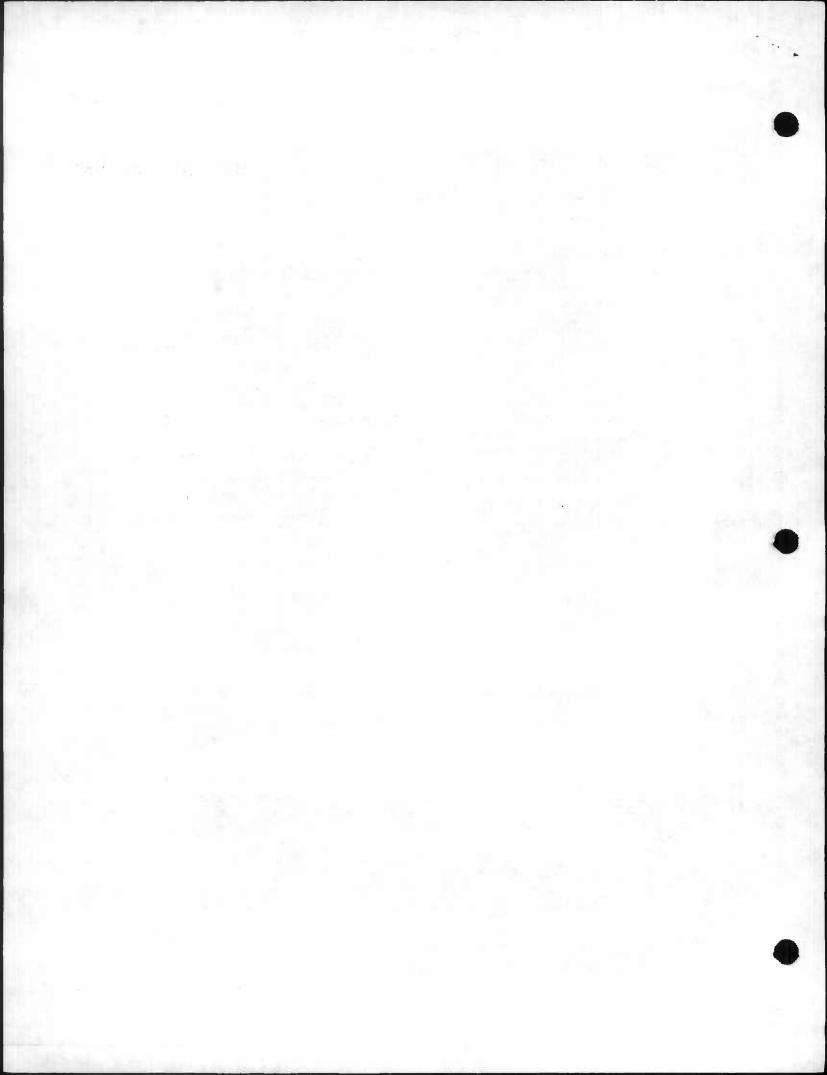
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHMFMAN WILLIAM 31. Date filed (Month, Day, Year)

32. Registrar's Signature Epera

10751 FALLS

OCT 13 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#4b&18 PER A.B. G776 10-13-99JA Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth 55 10 99 Mable G. Runge 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death BEL AIR Bolair Bull B. Date of Birth (Month, Day, Year) Mariner Health Belair Harford If Under 1 Year 7. Age (In yrs. lest birthdey) 5. Social Security Number Birthplace (Stete or Foreign Country) 1□ M 2☑ F Months Days Yrs. 87 16, 1912 215-10-6028 Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside Cltv Limits 1 ☐ Yes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 804 Jackson Blvd. 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Retail Sales College (1-4or 5+) Elementary/Secondery (0-12) Buyer 12 18. Mother's Name (First, Middle, Melden Sumame) 17. Fether's Name (First, Middle, Last) WEIMER Wimmer Calvert Jones Ada 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wayne Kirkman/executor 804 Jackson Blvd., Bel Air, MD 21014 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Signature of Fureral Service Licensee 22. Name and Address of Facility Director State Anatomy Board, 655 W. Baltimore St., Ronald Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) 2 months Pancreutic Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show a notified at

ed other than "natural", or items 23s or event, the Medical Examiner must be r

"natural", or

Pages 1 and ≥ should be filed within sent of Health and Mental Hygiene.

Baltimore,

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Department of Health a Important: If Item 27 is any injury or other tra-once.

Hygiene.

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Completed

Examiner

Physician/Medical þ Completed Be 2 Certification:

The law requires that the death certificate be axecuted physician and s the burial-trans O. Box 68760 signed by t Division of Vital Records, P. peen s hes Aftar this certificate Attending Physician: death. Director

6

24 hours e

To the I within 2 To the I complete

State

Medicai npletely

29c. License number

1 Yes

2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yeer)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huswill

North

Bil Air Manylund

1 3 1999 Registrar

1 Natural
2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature and title of certifier

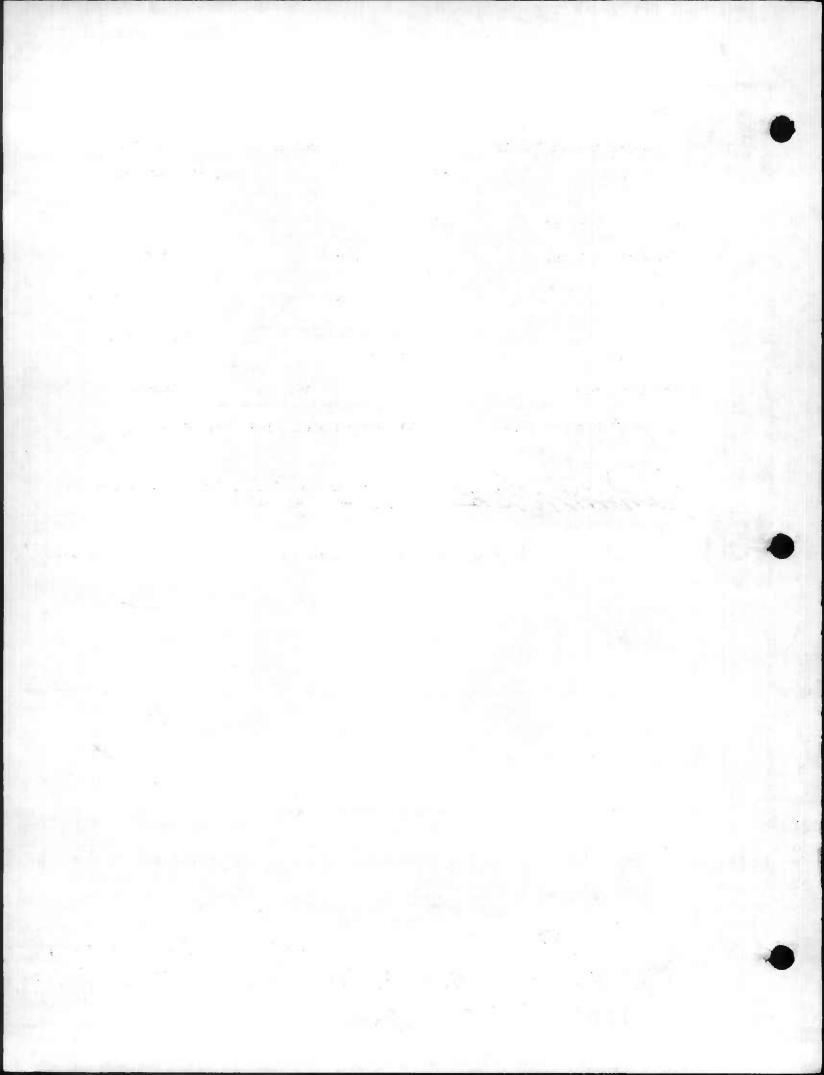
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5 Pending Investigation

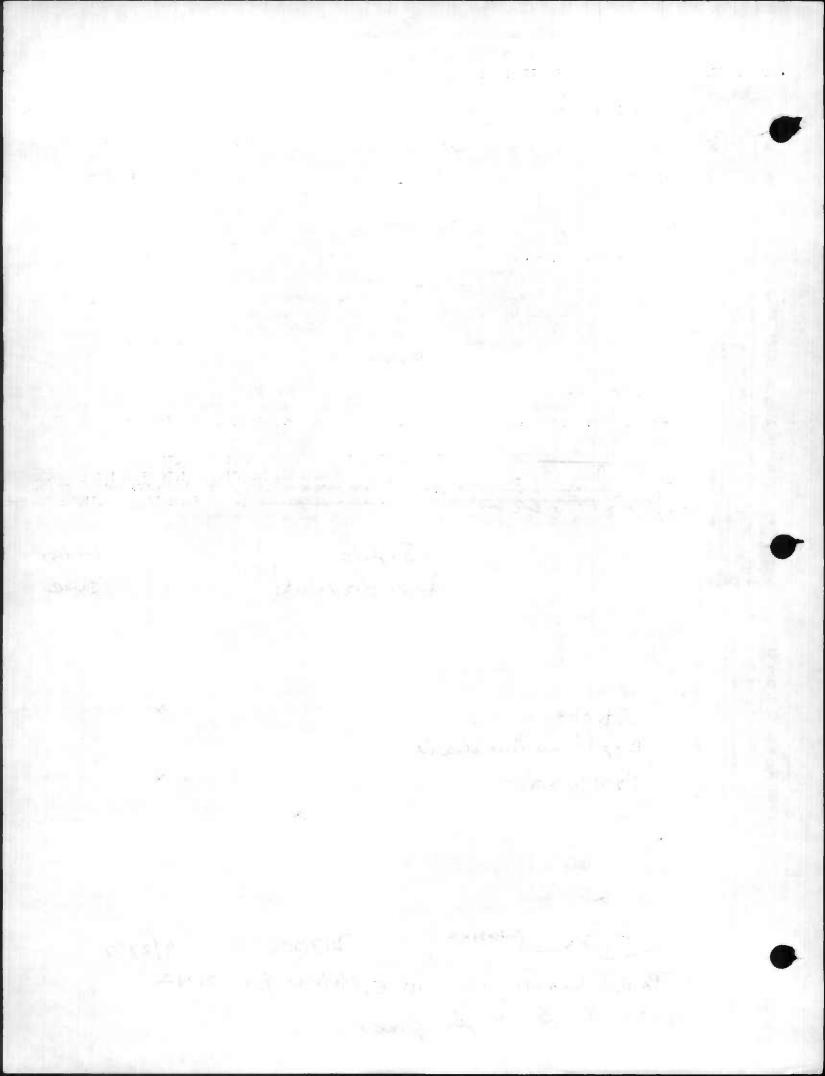
6 Could not be determined

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



	20a-20c,21 & 22 PER FH G			ertifica		Death		/giene	31931			
Physician	1. Decedent's Name (First, Middle, Last)						2. Dete of D Month	eeth Dey	Year 3. Time o			
/Medical		gley					9-	26-	99 3			
Examiner	4a Facility Neme (If not institution, give s	0			4	b. City, Town, or	Location of Dee	th 4c. County	of Deeth			
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pue *	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or	Location					10d. Inside C			
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Di ver					ip Code			U.S.A.	What Country?			
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items items instru		Armed Forces	nown	If Yes, sp	ecify Cuba	an, Mexican, Pue	to Rican, etc.)	Blac	ck, White, etc.			
ors eft.	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give		1□ Yes	2√ No	Specify:		Specify	y: White			
natural, or	Λ	Year or Detes:	40. 0	a de ada 11-		-41						
-ne ete	15. Decedent's Educ (Specify only highest grade	completed)	(Gi	edent's Usive kind of w DO NOT	ork done	during most of wo	orking		usiness/Industry			
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be flied within 72 ho tal Hygiene. d other than "nature event, the Moorest Be Completed	17. Father's Neme (First, Middle, Last)		Cosi	netolo	gy	18. Mother's Na	me (First, Middl	e, Malden Sumen	ne)			
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s marked o s marked o sumatic eve To Be	William Voegele 19a. Informent's Neme/Relationship (Ty)	ne Print)	10h 12-	iling Addes	ee (Ctreet			ber, City or Town,	State Zin Code			
than traur	John J. Eberhardt/								ourg, VA. 2			
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	21. Signature of Funeral Service License	THOMAS GREG	DR	State	Ana	ss of Facility CR EOMY BOA	rd. 655	W. Balt	MD INC. imore Stre			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year ROBERT SNYDER 7, 1999 4c. County of Death 5:53 PM OCTOBER 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death St. Paul Street n/a Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 X M 2 □ F Yrs 218-28-3386 Jul 25, 1931 68 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland n/a Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 St. Paul Street, Apt. 1903 21202 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yas, Giva Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elamentery/Secondary (0-12) College (1-4or 5+) Pharmicist Medical 12 17. Father's Name (First, Middle, Last) 18 Mother's Nama (First Middle Maiden Sumeme) Frederick Snyder Emma Hobson 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Drisgill/ Sister 1511 Adams View Road Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Metro Crematory 10/9/1999 Baltimore, Md. 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility 4107 Wilkens Avenue schie Mannon HUBBARD FUNERAL HOME Baltimore, MD 21229 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Approximete Interval Batween Onset and Death mult; Glioblastone Immediete Cause (Finel lome 2 years disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury Due to (or es a consequence of): that initieted evants resulting in death) Lest Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 Yas 3 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Neturel 5 Panding investigation 1 ☐ Yes 2 ☐ No

Box 68760. P.O. 1 Records,

physicien end the buriel-transit The law requires that the deeth certificate be executed P. 6 hes certificate Division of VItal To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

"naturel", or items 23a or 28a-f ahow

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelith and Mentel Hygiene. Important: if frem 27 is marked other than "natural", or hen any injury or other traumatic avent, the Medical Experimentals.

Physician

/Medical

Physician/Medical Examiner

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Completed

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2 Accident

3 Suicide

29a. Certifier (Check only one)

4 T Homicide

31. Date filed (Month.

Examiner

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

8

the Manyland

death with

edical Certification:

State Registrar

29b. Signature end title of certifier Lose Farzuelo, M.D.

28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify)

29c. License number DO053437

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

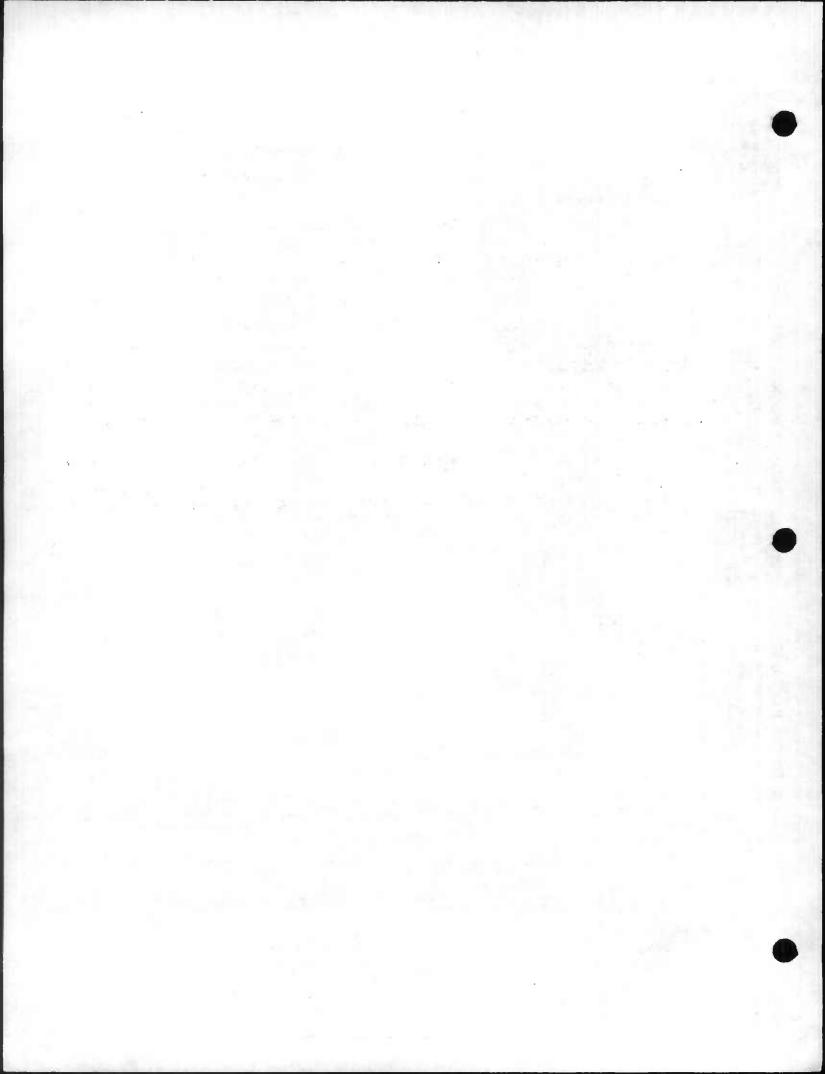
30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

6 ☐ Could not be

Day, Year)

tarzuelo 323 4.0. 32. Registrar's Signature

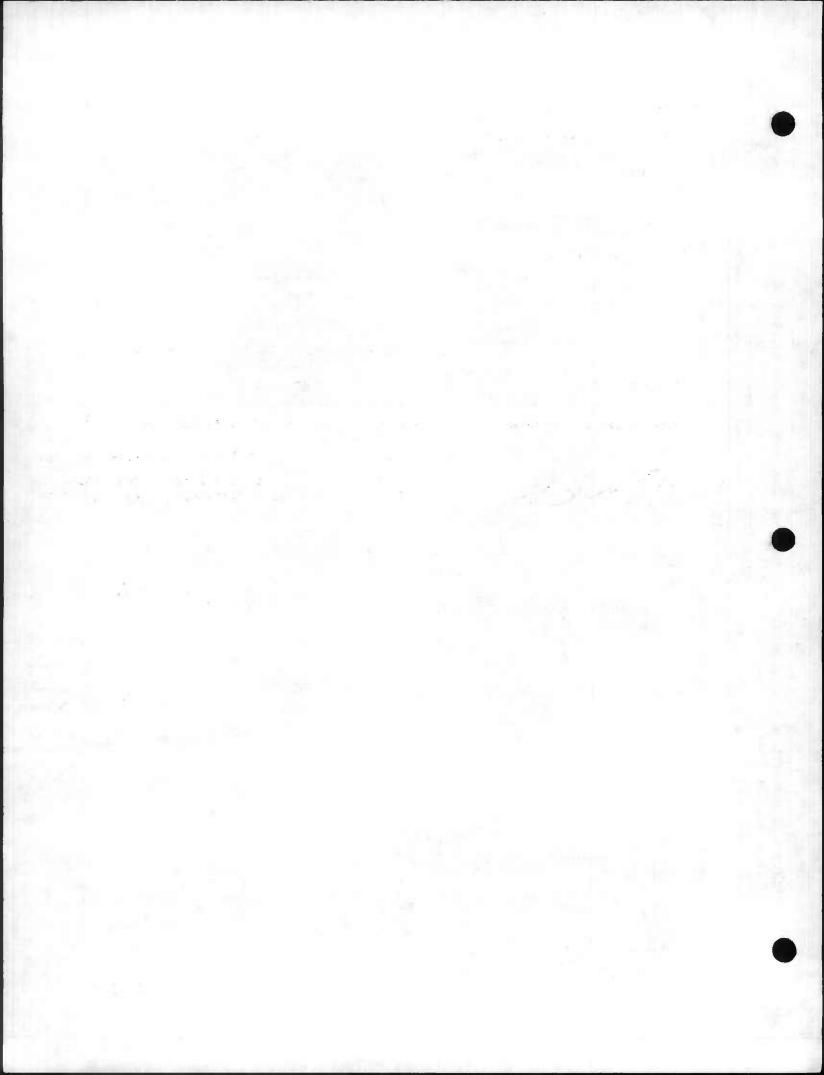
Celvert St. Belto, and



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Dev Month **Physician** 1999 11.25 P.M 78, OCTOBER Christine Marie Smith /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Hospital Westminster If Under 1 Yeer | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stel Country)
Oct. 22, 1905 Maryland 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 N F 213-09-4481 93 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yas 2 ☒ No Director Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5904 Dale 21784 U.S.A. Court Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detas: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. 72 hours efter 1 Never Marriad 2 Merried altimore, Maryland 21215-0020 natural, or Specify: White 1 ☐ Yes 2 ☑ No Specify: 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nant of Health and Mentel Hyglene. nnt: If itam 27 is marked other than "! Iny or other traumatic avant, the Men Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Casper Lutz Rose Will 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) 5904 Dale Court Sykesville, Maryland 21784 Jane F. Brown/ Daughter 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete to Burlel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 10/13/99 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Nema end Address of Fecility Hubbard Funeral Home, Inc. 21. Signative of Funeral Service Lice 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediete Cause (Finat disaase or condition resulting in death) /Medical NEUMONIA Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 1 ☐ Yes 2 No 1 Yes certificate Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Wes casa referred to medicel exeminer? Be 26. Place of Deeth (Check only one) Hospitet: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Naturel 5 Pending 1 Tyes 2 No 2 Accident investigetion 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicida 28e. Plece of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di Confifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted. Medical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi ane) 29d. Date signed (Month, Day, Year) 29b. Signature and ti 29c. License number DS 1245 OCTOBER 8,1999 30. Name and address of person who completed cause of deeth (ttem 23a) (Type, Print) SAJID SHAMIF COUNTY SENEROR GUSPIT MZ CMPROU 31. Dete filed (Month, Day, Year) 32. Registrer's Signetura State OCT 13 1999 Registrar

RHA



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** OCTOBER 10, SIENKIELEWSKI 1999 1:30 PM JOSEPH DANIEL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** BALTIMORE TIMONIUM STELLA MARIS HOSPICE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 12 M 2 ☐ F 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthpleca (State or Foreign **Funeral** Months Days Hours MARY LAND Yrs. JUNE 18, Director 214-22-3912 1927 Usuel Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ust be notified at 1. Yes 2 No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 2811 BRENDAN AVENUE 21213 U. S. A. Funeral death 14. Rece - American Indian, Bleck, White, etc. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Pages 1 and 2 should be filed within 72 hours after eard of Health and Mental Hypises.

ont if Item 27 is merked other than "haltural", or he may or other transmitted sevent, the Medical Examina my or other transmits event, the Medical Examina 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced U. S. A. Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) SERGEANT MAJOR - RETIRED U. S. ARMY 12TH GRADE 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be ANDREW SIENKIELEWSKI SOPHIA BRUCHALSKI 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 BRENDAN AVENUE, BALTIMORE, MARYLAND 21213 MRS. QUA SIENKIELEWSKI (WIFE) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, State 1

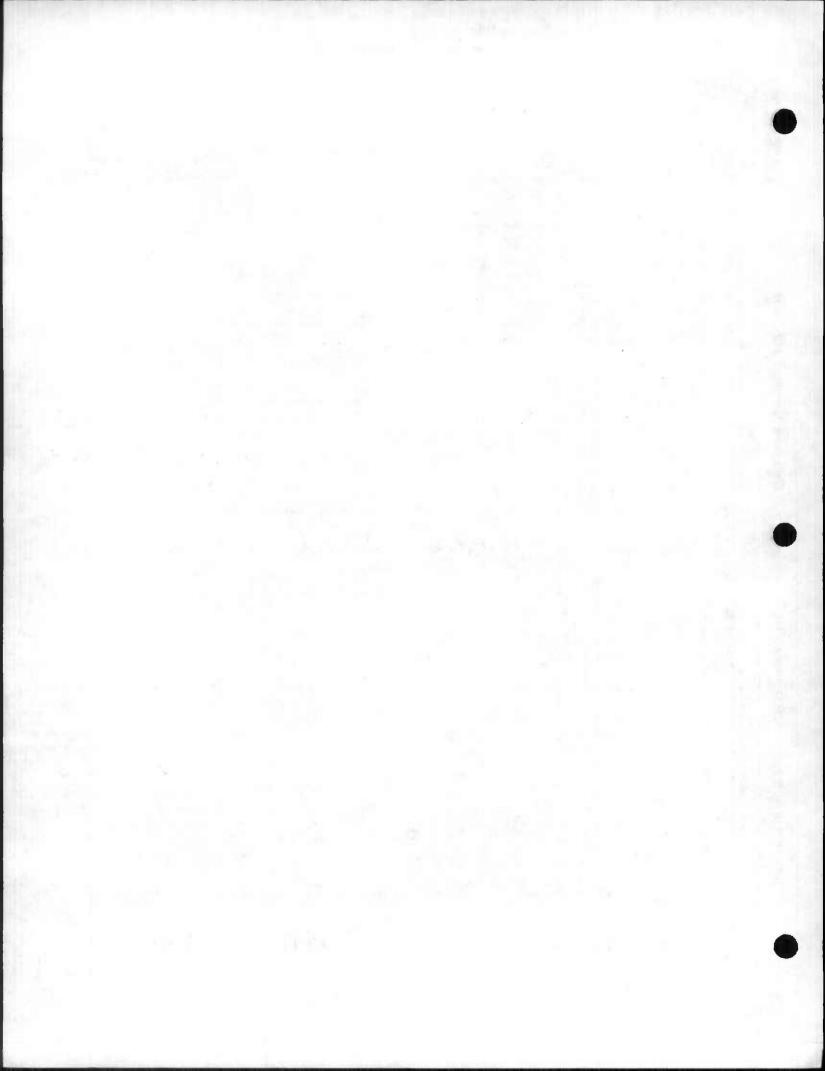
■ Buriel 2

□ Cremetion 3

□ Removel from Stete Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 10/13/99 BALTIMORE, MARYLAND PARKWOOD CEMETERY 21. Signeture of Funeral Service License 22. Neme and Address of Facility
SCHIMUNEK FUNERAL HOME INC. verdac Som 欠 3331 BREHMS LANE. BALTIMORE. MARYLAND 21213 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert failura. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** Proprate trimediate Cause (Final disease or condition resulting In death) /Medical IYR Examiner Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Sequentielly list conditions, if any, teeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequance of): Physiclan/Medical Due to (or as a consequence of): for usa as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Unknown by 24b. Wara autopsy findings availabla prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? page 2 21 No 1 Yes cartificate Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only ona) Hospitet: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ZONO Other: 4 Nursing Home 5 Residence 600 Other (Specify) Medical Certification: To this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28c. tnjury et Work? 28b. Time of 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) completely filled in by 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledga, deeth occurred at the time, date end place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha time, date end placa, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29d. Deta signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier October 11 BAX RIVE Nick Road 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ABB BATH 909-201 Registrer's Signeture State

DHMH 16 Rev 6/95

Box 68760, P.0. Division of Vital Records,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 12, 199 (c. County of Death Schwartz Robert Birthplace (State or Foreign Country) 1921 78 212-16-0113 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Anne Arundel Arnold 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

21012

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Metro Crematory, Inc. 10/12/99

Optometrist

20b. Place of Disposition (Name of cemetery, cremetory or other place)

23e. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA

Specify:

18. Mother's Name (First, Middle, Maiden Sumeme)

22. Name end Address of Fecility
Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

604 Oakland Hills Dr. Arnold, MD 21012

Beatrice Bass

16b. Kind of Business/Industry

Self-Employed

20c. Location - City or Town, State

Baltimore, MD

October 12, 1999

600 North Wolfe Street Bultimore Mary land

Approximete Interval Between Onset and Deeth

Forty eight hours

14. Race - American Indian, Bieck, White, etc.

White

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Department

Physician /Medical Examiner

mportant: if item 27 is marked other any injury or other traumatic avent, to once.

Physician

/Medical Examiner

10a. Stete

604 Oakland Hills Drive

15. Decedent's Education (Specify only highest grade completed)

Julius Schwartz

1 Buriai 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify)

1 Never Merried Married

3 ☐ Widowed 4 ☐ Divorced

Elementery/Secondery (0-12)

20a. Method of Disposition

31. Dete filed (Month, Dev. Year)

OCT 1 3 1999

17. Father's Name (First, Middle, Last)

19e. Informent's Neme/Relationship (Type, Print)

sturff of Funeral Service-Lice

Lila Rose Schwartz/wife

Thomas Gregor

College (1-4or 5+)

MD

Director

Funeral

à

Completed

Be

Funeral

Director

"natural", or items 23s or 28s-f show

with the Maryland

death v

The law requires that the death certificate be asscuted Division of Vitai Records, P.O. Box 68760, or Attanding Physician: death. Director 24 hours after Funeral Dire-letely filled in b

vithin 24 hour completely State Registrar **DHMH 16 Rev 6/95**

Immediate Ceuse (Finel disease or condition	. Acute po	ncreatitis			Forty eight h
resulting in deeth)	Due to (or as e consequence of):			
	b				
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (or as e consequence of):			
Cause (Disease or injury thet initieted events resulting in death) Last	C. Due to (or es e consequence of):			
	d				
Pert ti. Other significant conditions of	contributing to death but not re	sulting in the underlying ca	ause given in Pert I.	23b. Did tobacco use co	ntribute to the cause of death
coronary arter	y disewe			1 □ Yes 2 X No	3 Probably 4 Unknow
aute renal f	ailure			24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1□Yes 2×30	1 ☐ Yes 20 No
25. Wes case referred to medical examiner?			26. Place of De	eeth (Check only one)	
1 ☐ Yes 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient 3 DO	A Other: 4□ Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Menner of Death 1 Neturel 5 Pending 2 Accident investigation		28b. Time of Injury M	Bc. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 Sulcide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	iome, ferm, street, factory	28f. Location (Street end Numl City or Town, Stete)	ber or Rural Route Number,	
29e. Certifier (Check only one) 1 Certifying Pt	ysician: To the best of my kn niner: On the basis of exemin end menner steted.	owledge, death occurred outline end/or investigation,	ot the time, date and place in my opinion, deeth occ	ce, and due to the cause(s) end mo curred et the time, date end place,	anner as stated. and due to the cause(s)
OOL Cinnel - Aller - A - Aller	Sile illerine, eteled.	100-	Lianna aumbas	and Data single	d (Manth Day Vond

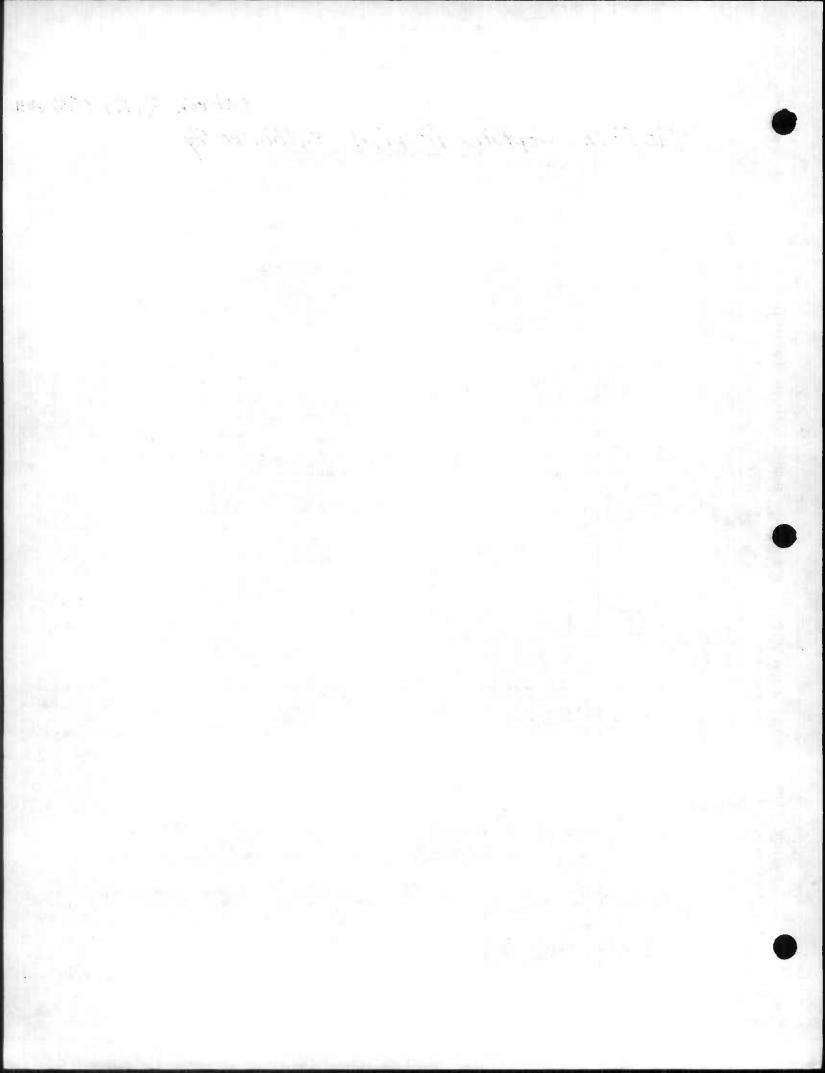
shysician Prerspn who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signeture

Johns Hopkins Hospita

RES

racks



Division

1 No 2 No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

29e Certifier

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated.

29c. License number

29b. Signeture end title of a

O.C.M.E.

29d. Date signed (Month, Day, Year)

21617

October 12, 1999

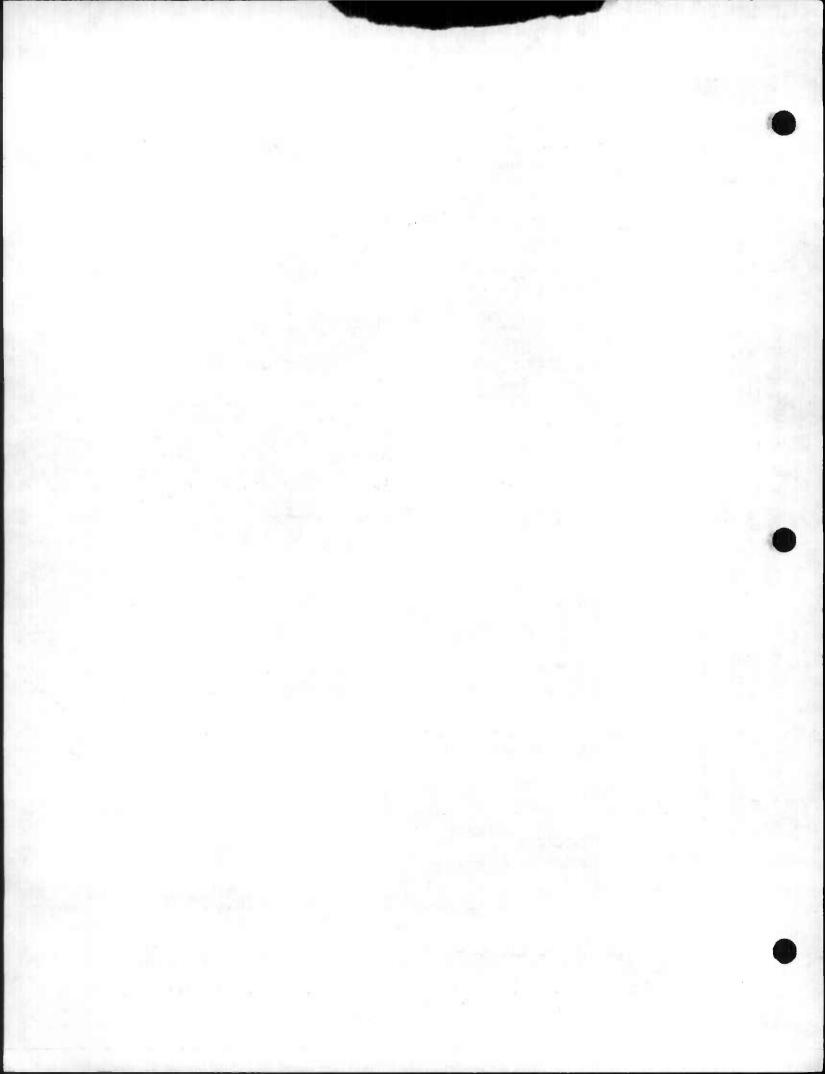
completed cause of death (Item 23a) (Type, Print)

05 ane 5

Lay. Year) 31. Dete filed (Month, OCT 1 3 1999

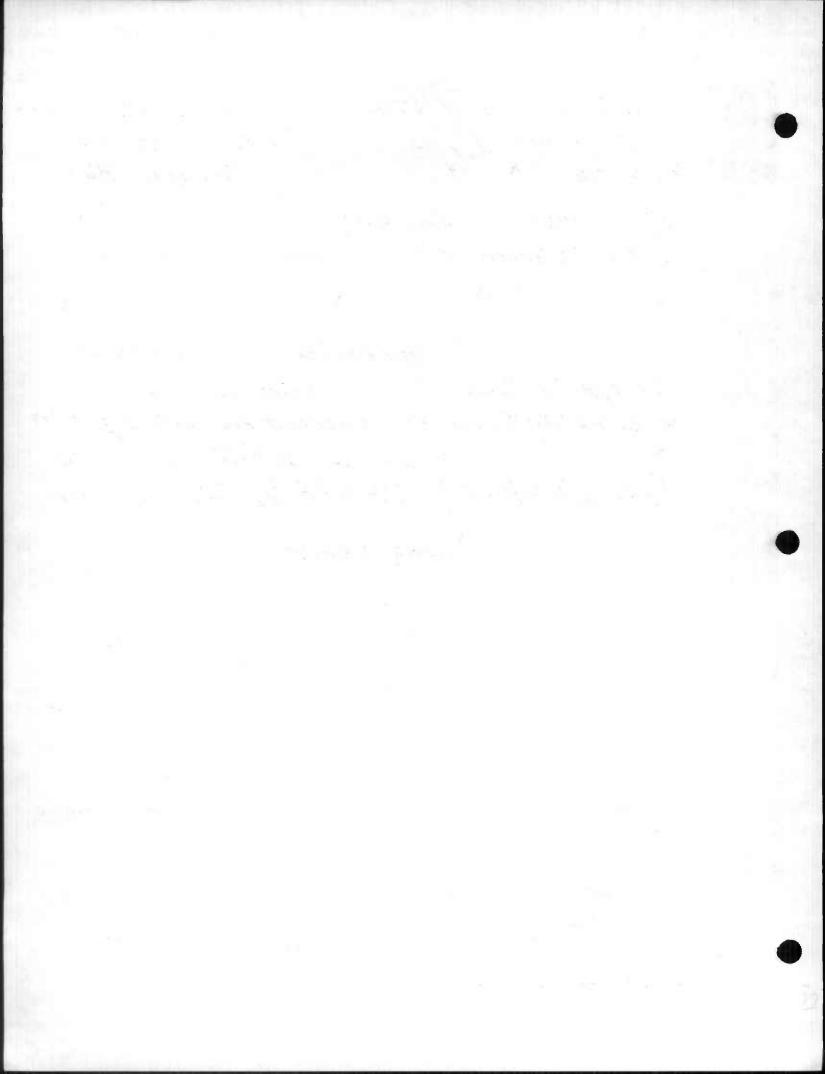
111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signature

State



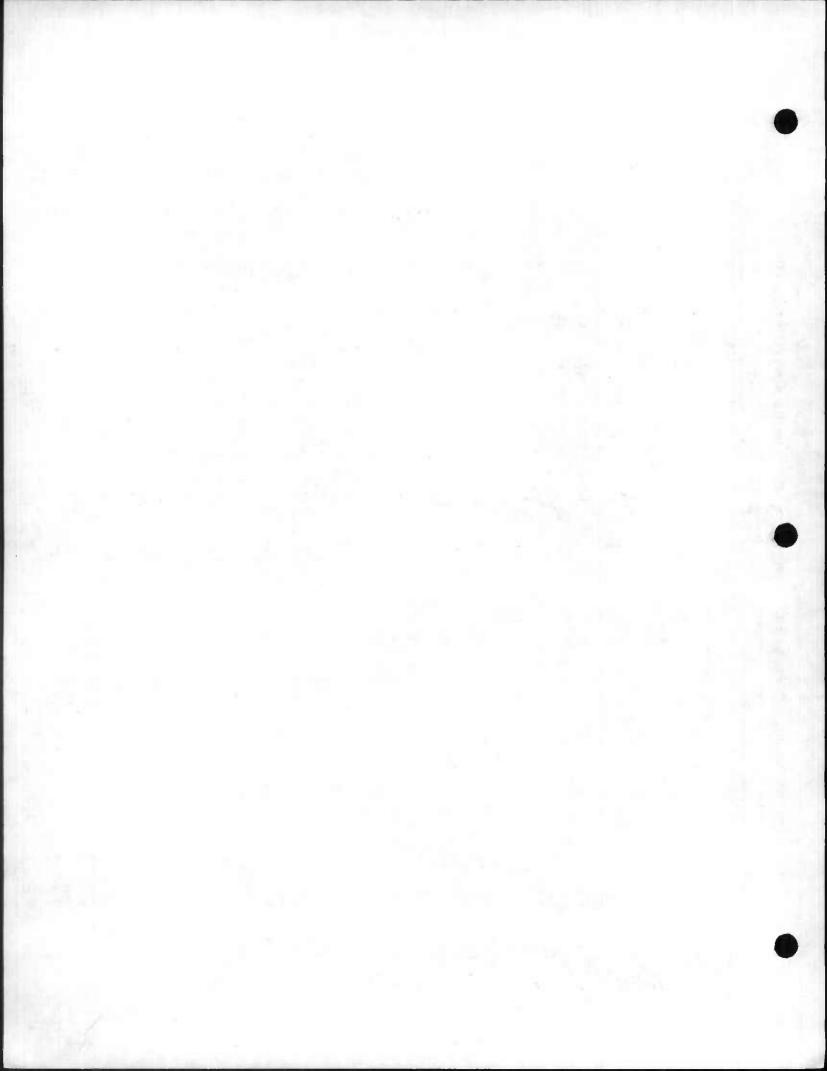
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	Exami		4e. Facility Nama (If not institution, give				4b. City, Town, or		4c. County		
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s	Funerai Director		5. Social Security Number 6. Social Security Number 7. Social Security Number 9. Social Security Number 1. Social Security Nu	1X 7. Ag	ga (th yrs. last birt	frs. If Under 1 Year Months Day			15,1915	9. Birthplac	ca (Stete or Foreig
	rland result		10a. Stata 10b. County		10c. City, Town	or Location				10d	l. Insida City Limits
	the Marylar 28a-f show	tor	MD. N/A	,	BAL	TIMORE					1 Yes 2□N
	or 28	Director	10e. Street end Number			10f. Zip Coda			10g. Citizan of	What Country	n
	23e		640 S. LAK	EWEOD	AUE.	2	1224		U.	5.A	•
020	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23e or 28e-1 show ont, the Medical Examinet must be multified at	by Funeral	11. Marital Status 1 Navar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Dacadant Armed Forces? 1 Yas 2 If Yas, Give Yaar or Datas:		13. Was Decadant of If Yas, specify Cu		specify Yes or No- to Rican, atc.)	14. Rac Blac Specify	ce - American ck, Whita, ato	
0-1	"natural",		15. Decedant's Ed	ucation	16a.	Decedent's Usuel Occ	upation		16b. Kind of B	usinass/Indus	stry
Maryland 21215-0020	within 7. ene. than "na	Completed	(Specify only highest grade Elamentary/Secondery (0-12)	de completed) Collega (1-4or		Give kind of work don life. DO NOT use retii	e during most of wo	rking		Hon	
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ary	should and Men smarke		19a. Informant's Name/Reletionship (7			Mailing Addrass (Street	et end Number or Ri	ural Route Numbe	r, City or Town,	Stete, Zip C	ode)
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ore	ges 1 it of He if item or oth		20a. Mathod of Disposition 1 Bunal 2 Cremation 3	Pemovel from State	20b. Placa of cemeter)	Disposition (Neme of , cremetory or other p	lece)	Deta 12	20c. Location	City or Town	i, Steta
E	artment ortant: I injury c		4 Donetion 5 Other (Specify		57.5	STANISLA	US CEM!	1999	BALTO.	Co.	MD.
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other tropose.		21. Signatura of Funaral Sarvice Licen:	iaa //	01.	22. Nama and Add	rass of Facility	29 HUL	SON S	7,	
ш	70 E 8 9		Thomas .	Mark	a p	SKARDA	F.H. BA	LTIMON	CE, M	D. 21	224
	Physician /Medical		23a. Part1. Entar tha disease, & comp shock, or haart failura. List only o Immediata Ceusa (Final diseasa or condition	lications thet causa ona causa on aach li	tha death. Do none.	. 0		c or raspiratory ar	rast,	In	pproximete nterval Batwaan ensat and Death
	Examiner	١	resulting in death)	α	Due to (or es e c	onsequance of):				i	
	pel list	nine		b				-			
o,	an end	Examiner	Saquantially list conditions, if any, leading to Immediata cause. Entar Undarlying Cause (Diseese or Injury		Dua to (or as a c	onsequence of):				1	
68760,	requires that the death certificate be executed seen signed by the attending physician end hould be deteched for use as the bunal-transit	edical	Cause (Disease or Injury thet Initiated avants resulting in death) Last	С	Dua to (or es e co	onsaquanca of):				1	
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P.0	by the detected	hys		This way to duction	at not racelling in	ino unduriying oddou ş	great in tracti.				bly 4 Limiknov
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no	ding Ph h. After th funeral	ion:	27. Manner of Death 1 ☑ Naturel 5 ☐ Panding	28a. Date of Inju (Month, De	ry 28b. T	jury W		28d. Dascribe h	ow injury occur	red	
Sio	leat or: the	cat	2 Accident Investigation 3 Suicide 6 Could not be	00. 00	41)		☐Yas 2☐No	004 1	N4	D 15	2014-01-01
Div	5 # # S	Certification:	4 Homicida determined	building, et	ury - At noma, far c. <i>(Specify)</i>	m, street, factory, offic	9	28f. Location (S City or Tow	n, Stete)	oer or Hurai F	oute Number,
	To the Hospital or within 24 hours eft or To the Funeral Dir completely filled in	edical (29a. Cartifiar (Check only one) 1 Certifying Phy 2 Medical Exam	alcian: To the best	axamination end	daeth occurred at the for invastigation, in my	time, date end plece opinion, daath occu	e, end dua to the currad at tha tima, c	ausa(s) and modata	anner as state and due to th	ed. ne causa(s)
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	,0/		30. Name end addrass of person who c	ompleted cause of d	aath (Itam 23a) (1						
	10		30. Name end addrass of person who co	D 821 A	1- En72n	. St. Snit	306 B	altimo	re M	D 213	10/

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edwin R. Strode, Sr. 10 04 99 9.20pm /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 3213 Everlasting Lane Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7 - 5 - 3 3 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 493-32-1084 1 3 M 2 □ F Yrs. Director Missouri Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director r 28a-f a MD Baltimore Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Items 23a or 3213 Everlasting Lane 21221 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiens.
Important: If them 27 is marked other than "natural any Injury or other treasments." 1 Yes 2 No If Yes, Give 1952 Yeer or Dates: 1 Never Merried 2 → Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer 12 Construction 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Reuben Strode Cora Munkins 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3213 Everlasting Lane, Balto, MD 21221
ca of Disposition (Name of Date 20c. Location - City or Town, Stete Carolyn L. Strode 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 Burial 2 Cremetion 3 Removel from Stete St. Stanislaus 10-8-99 Balto., MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Lim 22. Name end Address of Facility Kaczorowski Funeral Home 2 1201 Dundalk Ave., Balto., MD 21222 23a. Pert1. Enter the diseese, or shock, or heart feilure. List meth. Do not enter the mode of dying, such as cerdiac or respiretory errest, Physician EXTENSIVE SMALL CELL LUNG Immediate Cause (Finel disease or condition resulting in death) /Medical 5 months Examiner Examiner physician and s the burial-transit law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): for use as been signed by the a should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No cartificata Division of Vital or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of After 1 Natural 5 Pending n 24 hours after death.
Ne Funeral Director: After pletely filled in by the fun investigetion 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 101 State Registrar



Funeral Director

somerville, Manio

Box 68760,

P.O.

Records,

Division of Vitai

or Attending

Piease Type or Print in Biack indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Month Day Vear **Physician** MANIA J. SOMERVILLE OCTOBER 12 1999 2:00PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Days Months Hours 10 M XX 033-24-4744 66 06-30-1933 MASSACHUSETTS Usuat Rasidence of Decedant 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits man be notified at MD. N/A BALTIMORE CITY KOWes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 16 WEST FRANKLIN STREET 21201 U.S.A. Name 23a Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas **XX** No If Yas, Give Yaar or Dalas: Was Decedent of Hispanic Origin? (Specify Yaa or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Bace - American Indian 11. Merital Status Black, White, etc. 1 Nevar Married Merried "natural", or 1 ☐ Yas XX No Specify: WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied within 72 Department of Health and Mental Hyglenn. Important: if hem 27 Ia marked other than "nat any injury or other traumatic avant, the Madical PRG. INVESTMENT Elementary/Secondary (0-12) College (1-4or 5+) COUNSELORS ADMINISTRATIVE ASSISTANT 12 YEARS 18 Mother's Name (First Middle Maiden Sumema) 17. Fethar's Nema (First, Middle, Last) Be WALTER J. KUKLA **JEAN** KANIGOUSKI 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) JOHN H. SOMERVILLE (HUSBAND) 16 W.FRANKLIN ST., BALTIMORE, MD., 21201 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removel from Stata GREEN MOUNT CREMATORY 10-13 BALTO., MD., 21202 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funaral Service Licensee 22. Nama and Address of Fecitity
HENRY W. JENKINS AND SONS COMPANY P.H utt 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Inlarval Between Onset and Death **Physician** ancreatic /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Due to (or es e consequence of) Examine physician and s the burial-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) 88 980 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas KINO 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yas 2 ☐ No certificate 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) 1 Yas 2 No 27. Manger of Death Hospital Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA this 28a. Deta of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural
2 Accident To the Hospital or Attain.
within 24 hours after deeth.
To the Funeral Director: After the Funeral Director: After the Attained in by the fit 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifie: (Check only one) 29b. Signatura and title of gertifier 29c. License number 29d. Data signed (Month, Day, Year) 10 30. Nama and addrass of person who completed causa of deeth (Item 23a) (Type, Print)

State Registrar

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Celano

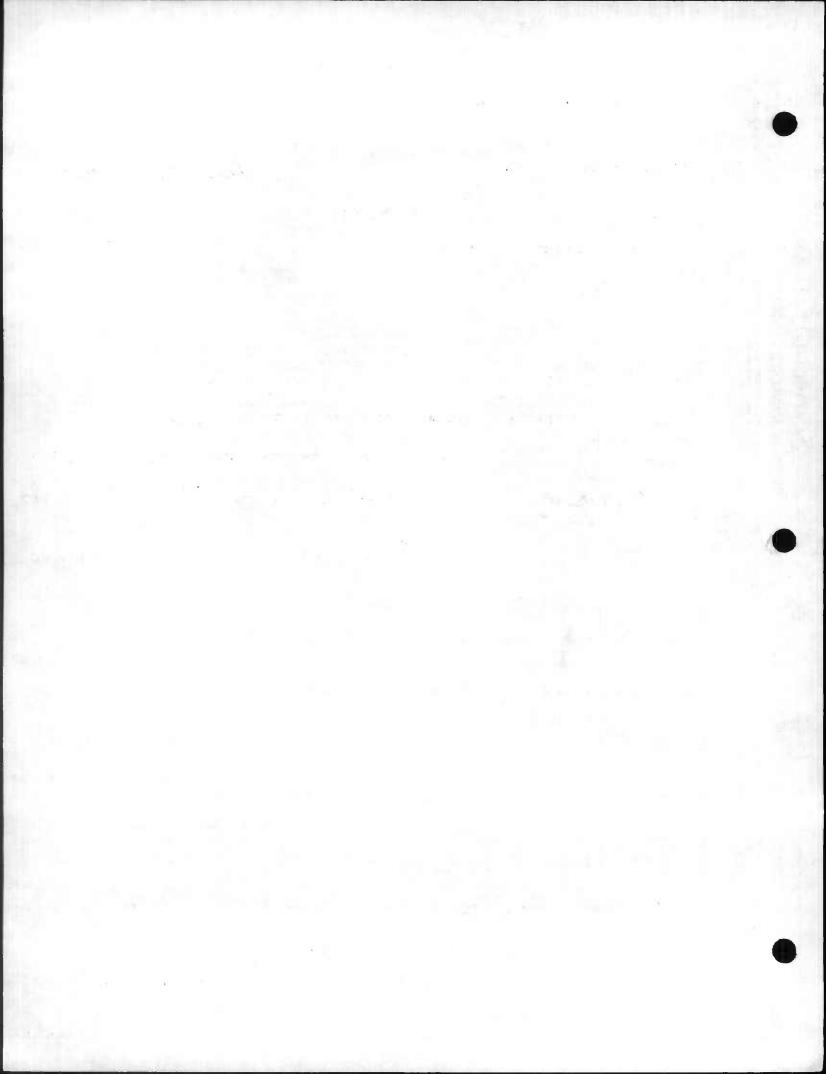
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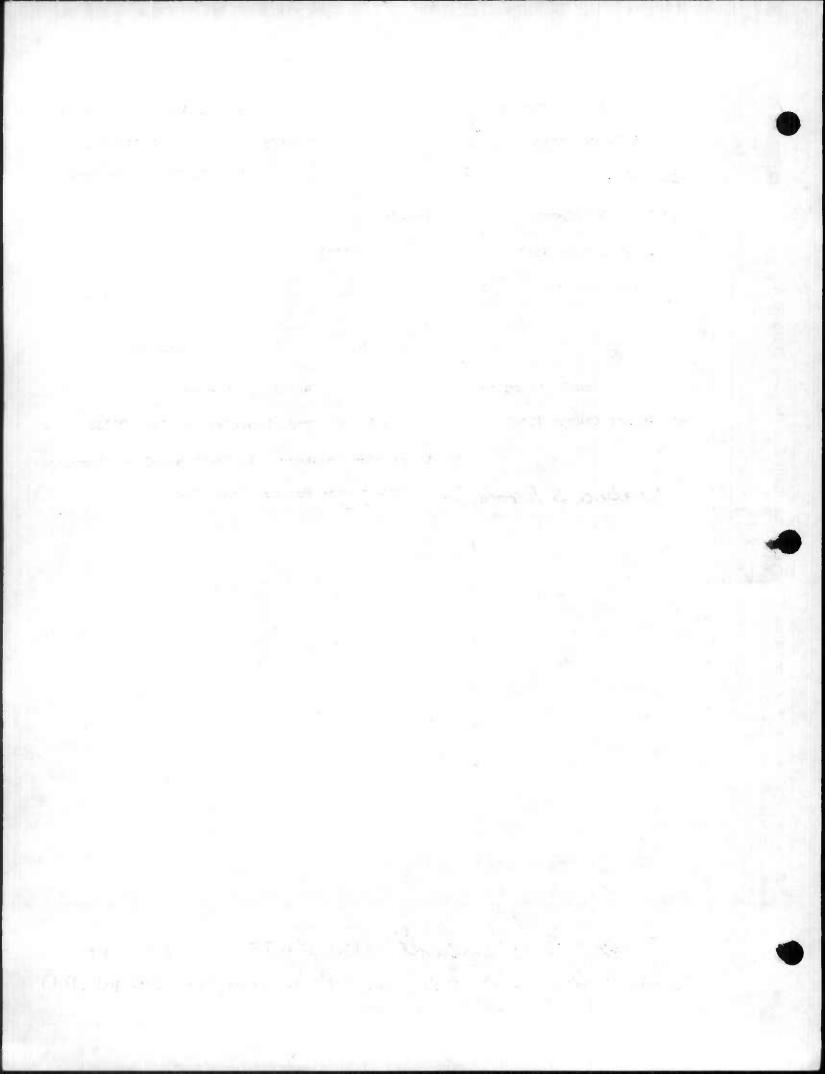
32. Regisfrar's Signature



State of Maryland / Department of Health and Mental Hygiene

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						Ce	ertificat	e of	Death		F	eg. No.		01290			
Physician	ı	1. Decedent's Name	(First, Middle, L.	ast)							2. Date of Dea Month		Year	3. Time of Death			
/Medical	ı.		fie	Stamas							October		999	10:30 A.M			
Examiner		4a. Facility Name (If			ım <i>ber)</i>				4b. City, To	wn, or L	ocation of Death	4c. Cour	nty of Deeth				
8 17	Ц		ardon Ro						Phoe		_		altim	ore			
Funeral Director		5. Social Security Nur 219-90-54 Usual Residence of D	80	Sex 1□M 祭□F	7. Age (In yrs. le 79	est birthday Yrs.	Months	Days		24 Hrs. Min.	8. Dete of Birth (Month, Day 5-28-1	, <i>Year)</i> 920		place (State or Foreign ntry) York			
Mo W			10b. County		10c. City	Town or L	ocation							10d. Inside City Limits			
r 28a-f show nooffed at	5	Maryland	Baltimo	ore		Phoen	ix							1 ☐ Yes 2 ☐ No			
0.8	2010	10e. Street and Number 13600 Bardon Road 21131							1	0g. Citizen o	of What Cour	,					
items 2	5	11. Maritai Status		12. Was Dec	edent Ever in U,S	3. 13.				ain? (Sp	ecity Yes or No-		ace - Americ				
by F		1 ☐ Never Married 3 🖾 Widowed 4		Armed For 1 Yes, Giver or D	2 X No		If Yes, spec				ecify Yes or No- Rican, etc.)		lack, White,	etc.			
d other than "natural", svent, fre Modes Ex.		(Specific	5. Decedent's E	ducation		16a. Dece	dent's Usua	ei Occu	pation	t of work	ina	16b. Klnd of	Business/In	dustry			
	2	Elementary/Second		College (during most ed)	I OF WORK	ung						
Is marked other than raumatic event, tre M	5	17. Fether's Name (F	2			HO	memake	er				Own	Home				
Item 27 Is marked other other traumatic event,		17. Fether's Name (F	irst, Middle, Last	")					18. Mothe	r's Nam	e (First, Middle, I	Maiden Sum	ame)				
To affe	2		Frank	Sagoul	as				Ang		Mento						
ls me		19a. Informent's Nam				19b. Mail	ing Address	(Stree	t and Numbe	er or Rur	ra/ Route Number	, City or Tou	n, Stete, Zip	Code)			
ner tr	-	Mr. George		(Son)					Road	, Ph	oenix, 1	Maryla	nd 213	131			
important: If liem 27 I any injury or other tra ance.	1	20a. Method of Dispo 1 □XBuriai 2 □		Removai from		ace of Disp metery, cre	osition (Nan	ne of ther pla	ace)		Date	20c. Location	n - City or To	own, State			
ury or of		4 Donation 5			Gree	ek Or	thodox	c Ce	meter	y .	10-14-99	Dood (lawn.	Maryland			
Important: any injury ance.		21. Signature of Fund			0				ess of Facilit					ar y rana			
Importan any injur once.	۲	Wall	lace 5	Bloom	by 21	Rı	ack To	wsc	n Fune	eral	Home,	Inc.					
attending physician end Web and Ifor use as the buriel-trensit and Ifor use as the dical Examiner	medical Examiner	Side of the contract of the co	Side of the contract of the co	S ill	Immediate Cause (Fidisease or condition resulting In death) Sequentially list cond feny, leading to immause. Enter Underly Cause (Disease or in) hat initiated events resulting in death) La:	litions, ediate ring lury	a	Due to (or a	es a conse	quence of):	He	87	Des	ally			gro
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igned by the attend be deteched for us by Physician											1 🗆 Y			bably 4 Unknown			
2 should											24a. Was a perform		av	ere eutopsy findings eilebie prior to mpietion of cause death?			
pege Com											1 □ Ye	s 2 No	10	☐ Yes 212 No			
director, p		5. Was cese referred	I se friedical						26. Piece	of Deat	h (Check only on	4					
00		1 ☐ Yes		Hospital:	npatient 2 E	R/Outpatie	nt 3 DO	A Ot	her: 4 Nu	rsing Ho	me 5 Reside	nce 6 🗆 O	ther (Specif	(v)			
After the funera	2	2 Accident	5 Pending investigation	1	of Injury th, Dey Yeer)	8b. Time o Injury	M 2	8c. Inju Wo 1			28d. Describe ho						
od in by the		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	of Injury - At hom ng, etc. (Specify)	ne, farm, st	reet, factory	, office			28f. Location (St. City or Town	reet end Nun , State)	n <i>ber</i> o <i>r R</i> ura	Route Number,			
To the Funeral Di completely filled in Medical Cer		9e. Certifier 15 (Check only 25 one)	Certifying Ph Medical Exam	niner: On the pa	best of my knowing asis of examination are stated.	edge, deat n and/or in	n occurred a vestigation,	at the ti	me, date end opinion, deat	d piace, h occurr	and due to the ca	use(s) and rete and place	nanner as st	eted. the cause(s)			
omp Me		9b. Signature and titl	e of certifier	. /) 1		290	Licen	se number		2	d. Date sign	ed (Month,	Day, Year)			
		Day	and 1	1-11	0 1	1	- 0	70	0151	7	2	I'm	100	0			
D	3	0. Name and address	of person who	completed caus	e of death (Item 2	(Type	Print)	0	0106	10	2	10-	12-				
	-	Joseph Y	4 Rev	apara	ct m)	2000	3 1	Rock	Sp	ring R	1 For	est H	am. II.			
State	3	1. Date filed (Month	P 109 10	00 32 H	ogistrar's Signatu	10 /4	1		1,	-) "	3.0					
Registrar		O.C.	To 12	100		1.	1000	MA	2								

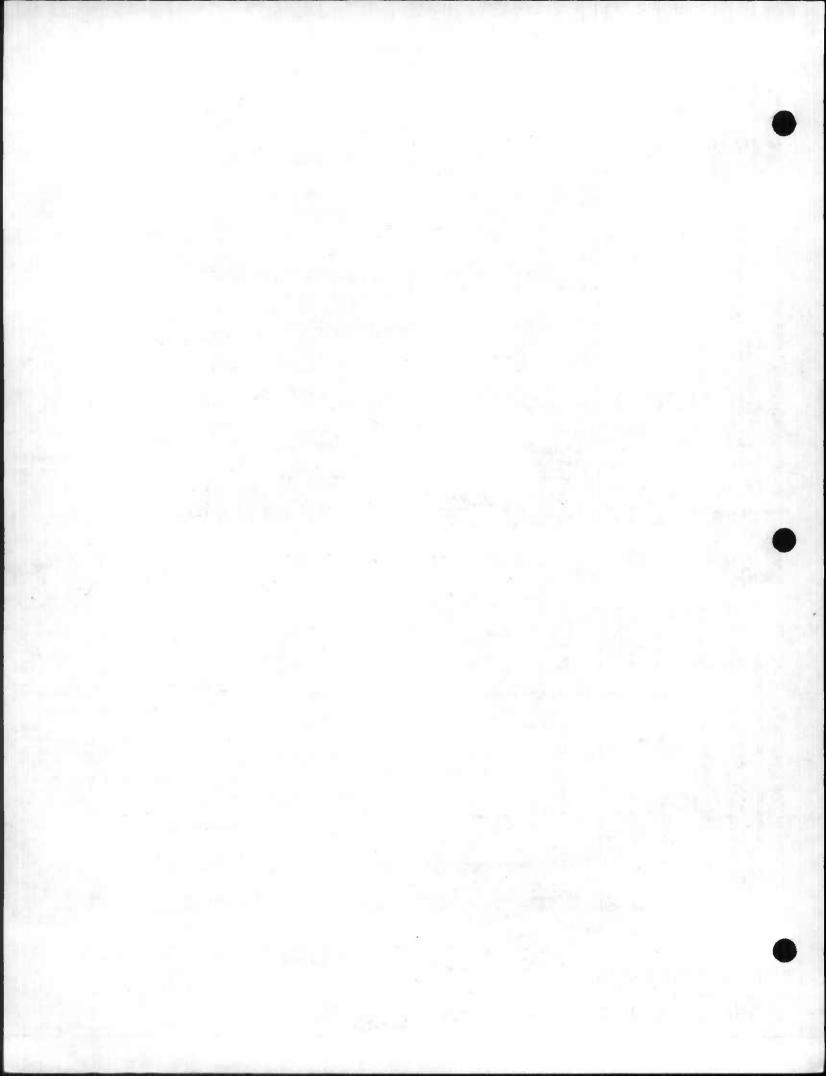


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 23:50 SEPTEMBER 28 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hogistus

5. Social Security Number 6. Se THER MYVIEN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 F Yrs. Director 27, 1930 unknown 218-28-4741 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4320 Clareway Apt. 3 21222 Funeral U.S.A. 12. Was Decedent Ever in U,S.
Armed Forces?

1 □ Yes 2 □ No
If Yes, Give
Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Marital Status unknown Black White etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) parmit. Pages 1 and 2 should be file. Department of Health and Mental Hi Important: If fleen 27 is marked oth any Injury or other trearmatic event RASS. Be 2 unknown unknown 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown 20a. Method of Disposition 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donetion 5 □ Other (Specify) in state ture of Funeral Service Licensee 22. Name and Address of Fecility Ronald S. Director State Anatomy Board, 655 W. Baltimore Street Wade, Mull run 11 Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shark, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset and Deeth **Physician** /Medical tmmediete Cause (Finel disease or condition resulting in death) Examiner Examiner physician and s the burial-transit that the death cartificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably Unknown been signed t should be det Records, by The law requires 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy page 2 a 1□ Yas 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physician: director. 25. Was case referred to medical axaminer? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 1 ☐ Yes 2 €No 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Naturel 2 Accident 5 Pending death. 1 Yes 2 No investigetion Director: 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 124 hours after d 4 - Homicide within 24 hour filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the and manner steted. edical 29e. Certifier (Check only one) mination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number ne and address of persor of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) OCT 13 1999 Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	1. Decedent's Nama (First, Middle, Nobuko	Kawama				2. Data of De Month	OH I	Voor -	Time of Death	
Examiner	48 Facility Nama (If not institution,) Luhas Hupkins	Bayriew M	edical	Center	The same of the same of the same of the	mre		of Death		
Funeral Director	5. Social Security Number 226-76-0291 Usual Residence of Decedent	. Sex 7. Aga (In 1	yrs. last birthda 66 Yrs.	y) If Under 1 Yes Months Day			rth ay, Year) 1933	9. Birthplace Country) Taiwan	9. Birthplace (State or Foreign Country) Taiwan	
ž u	10a. Stata 10b. County	100	. City, Town or	Location				10d. In	side City Limits	
notified	MD Baltim	ore	Baltimo	re				1	☐ Yes 2 No	
Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of	What Country?		
	9 Barletta Cour	t		212	37		U.S.A			
by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forcas?	1 ☐ Yas 2 ☐ No If Yas, Giva 1 ☐ Yas 2 ☐ No Specify:							
pet	15. Decedent's	Education	16a. Dec	edent's Usual Occ	cupation	advin a	16b. Kind of B	usiness/Industry	,	
Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life	emaker	ne during most of w ired)	orking	Own Ho	me		
BeC	17. Father's Name (First, Middle, La	st)			18. Mother's No	ame (First, Middle	e, Maiden Suman	ne)		
To	Setsumi Kawamot	0			Sumiko	Munemor				
770	19a. Informent's Neme/Ralationship	(Type, Print)	19b. Ma	iling Address (Stre	eet and Number or F	Rural Route Numb	ber, City or Town,	, State, Zip Code	9)	
	Merrill H. Schl	icker/spouse	9 B	arletta	Ct., Balt	imore, MD 21237				
	20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from Stata 4 Ponation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Total cemetery, crematory or other place)									
8008	C. Winumi	S. Wader Dir	ector	Baltimon	natomy Bore, MD 2	1201			coximate	
cian lical iner	23a. Pan1. Entar tha disease, or constitute. List or the shock, or haart failura. List or the shock or case (Final disease or condition rasulting in death)	a. he	patu to (or as a cons	requence of):	syndn			Inter	val Between et and Death	
n/Medicai Examiner	Sequentially list conditions, if any, leading to immediata causa. Entar Undartying Cause (Diseesa or injury that Initieted avents rasulting in deeth) Last	c. he	to (or as a cons	equence of):						
ysician	Part II. Other significant conditions	d.	resulting in the	underlying causa	given in Part I.	23b. Did	I tobacco use co	ontribute to the	cause of death?	
y Ph	systemic lu	pus erytr	iema.	tomis		1	Yes 200No	3 Probably	4 Unknown	
cate has been signed by the etter page 2 should be detached for Completed by Physicial	systemic lu	el obstrue	chm			24a. Was perf	s an autopsy formed?	availabl	utopsy findings e prior to lion of cause 17	
E						10	Yes 28 No	1 ☐ Yes	2 No	
Be Com	25. Wes casa rafarred to medical				26. Place of D	eath (Check only	one)			
0	examiner?	Hospital: 1 Dippatient	2 ER/Outpat	ent 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	idence 6 Ott	ner (Specify)		
e funeral director, atton: To Be	27. Menner of Death 1 ONeturel 5 Pending 2 Accident Invastigat	28a. Dete of Injury (Month, Day Yea	7) 28b. Time tnjury	V	-	1	how injury occur			
led in by the funera Certification:	3 Suicida 6 Could no determine	28e. Place of Injury - building, etc. (Sp	At homa, farm, ecify)	street, factory, office	CO CO		(Street and Numi own, State)	ber or Rural Rou	te Number,	
To the Funeral Director: At completely filled in by the fu Medical Certification	29a. Cartifiar (Check only one) 1 Certifying 2 Medicat Ex	Physician: To the best of my aminer: On the basis of axan and mannar stated.	knowledge, de nination end/or	ath occurred at the investigation, in m	tima, data and plac y opinion, death occ	ce, and due to the	cause(s) and m , date and place,	anner as stated.	cause(s)	
Semple Semple	29b. Signatura and title of certifiar			29c. Lice	ense number		29d. Date signe	ed (Month, Day,	Year)	

State Registrar

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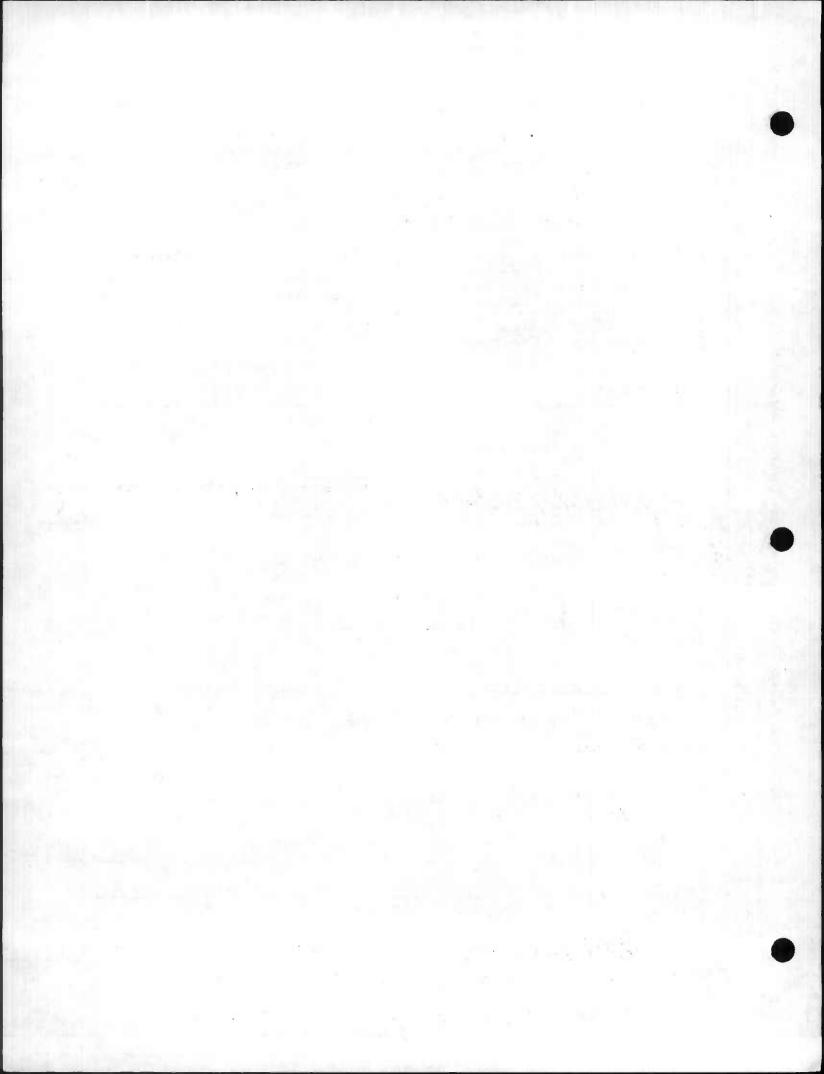
31. Date filed (Month, Day, Year) OCT 1 3 1999

32. Registrar's Signatura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
Stasia Reynelds, MD Johns Hapkins Bryview Medical Center, Buthmore 21224 Sports

98030

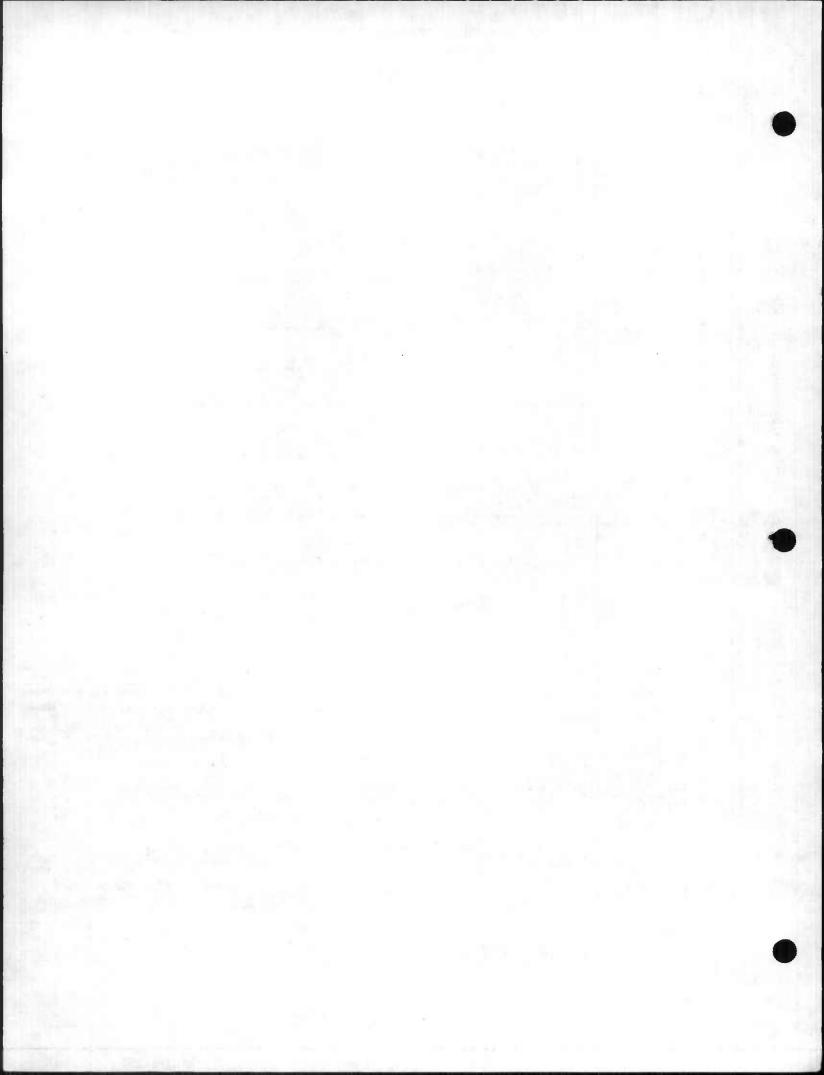
October 4, 1999



ella Tippe	tt State of M		ertificate of D	alth and Mental I eath	Hygiene 99	31946				
Physician /Medica Examine	4a facility Nama (If not institution, give street and number)	T: ppe	46.	2. Date of Month of City, Town, or Location of E	ber 10, 19	Death				
Funeral Director		a (In yrs. last birthday)	If Under 1 Year	Hours Min. 8. Data of Month	,	Birthplaca (Stata or Foraign Country) Maryland				
show show date	Usual Residence of Decedant 10s. Stata 10b. County	10c. City, Town or L				10d. Inside City Limits 1 🕱 Yas 2 🗆 No				
th with the Maryla 23a or 23a-f sho unt be notified at	Maryland N/A 10e. Street and Number 1011 DeSoto Road	Baltimor	10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.					
her dos	11. Maritel Status 12. Was Decedent Armed Forcas? 1 Nevar Married 2 Married 1 Yes 2 X			vanic Origin? (Specify Yas o Mexican, Puerto Rican, atc. Specify:		American Indian, Whita, atc. White				
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiers. The marked other than "nature", or traumatic event, the Medical Exam TO Be Convoleted by		(Give	edent's Usual Occupati a kind of work done du DO NOT use retired)	on ing most of working	16b. Kind of Busi	S. S. S. S.				
yland A	17. Father's Name (First, Middle, Last)			8. Mother's Name (First, Mi Unknown	ddle, Maiden Surnama,					
E 20 04 16	19a. Informant's Name/Ralationship (Type, Print) Nancy Peters (Daughter)		ling Address (Street and DeSoto Ro	ad, Baltimo						
Baltimore, emit. Pages 1 a Apartment of Ha Mportant: if Nem iny Injury or othe IDGS.	20a. Method of Disposition 1 Burlal 2 Crametion 3 Ramoval from State 4 Donetion 5 Othar (Specify)		osition (Nama of omatory or other place) Ll Cemeter			e, Maryland				
Balt permit Depart Import any in	21. Signatura of Funeral Service Licensee	1 5	2. Nama and Address Schimunek F 3331 Brehms	or Facility uneral Home, Lane, Balt	Inc. imore. MD	21213				
w 68760, antificate be executed ling physician and set the burial-transit medical Examiner.	shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	, ,	equence of):	9	W MEDICAL EXAMINER	Intarval Setween Onset and Deeth				
Cords, P.O. Box 6i v requires that the death certific been signed by the attending p should be detached for use as:	Part II. Other significant conditions contributing to death b	ut not resulting in the t	underlying causa given			ribute to the cause of death?				
0 9 20 5				App	Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of causa of death?				
Vital Re incien: The law certificate has irector, page 2	25. Was casa rafarred to medical				1 ☐ Yas 2 ☐ No only ona)	1 Yas 2 No				
Division of the property of the formula of the formula of the formula of in by the funeral december of the funeral of the fune	25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 27. Mannar of Death 1 Natural 27. Mannar of Death 1 Natural 28. Date of Injury (Month, Day Year) 10 01 - 1999 28. Date of Injury 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 5									
W 7	30. Name and address of person who ampleted causa of c	-		386	october	13, 1999				
State Registrar	31. Data filed (Month, Day, Year) DCT 13 1999 32. Registr	creen e	Sports	more MD	21201					

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1. Decedent's Name			am Tuli	Ly			2. Date of D Month SEPTEM	Day	Year 999	1709 PM
						4b. City, Town, or BALTIMO		th 4c. County o	f Death	
5. Social Security N 217–86–3	4)3	Sex M 2□ F	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hr. Hours Mir		2, 1960	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of 10a. Stete MD	10b. County N/A			Town or Loc					10	d. Inside City Limits
10e. Street and Nur				11011110	10f. Zip Code			10g. Citizen of W	hat Countr	
1633 CI	E 2.4	Stree	t		212	30		USA		
11. Meritel Status 1. Never Marri 3 Widowed	ed 2 Married	Armed F	2X No	II.	as Decedent of New Yes, specify Cub	tispanic Origin? (an, Mexican, Pue Specity:	Specify Yes or N rto Rican, etc.)		- America , White, e	
(Spec	15. Decedent's E ify only highest g ndary (0-12)	rade completed	(1-4or 5+)	16a. Decedent's Usuat Occupation (Give kind of work done during most of work life. DO NOT use retired) Automotive Body Repair				16b. Kind of Bus		ustry
17. Father's Name	First, Middle, Las	บ		Automo	cive Bo	-		Body SI		
	Willia		y				Donn	a Clift	on	
19a. informant's Na	me/Relationship	(Type, Print)		19b. Meiting	Address (Street	and Number or F	Rural Route Num	ber, City or Town, S	Stete, Zip (Code)
		Removal from	20b. P	ametery, crem	atory or other pla	on St. ∞) Inc. 10	1	ore, MD 20c. Location - G Balti		
21. Signature of Fu	omus Gr	Du	you					Maryla		
disease or condition resulting in deeth) Sequentially list conditions are sequentially list conditions. Enter Under Cause (Disease or thet initiated events resulting in death) if	nditions, imediate rhying Injury	o	Due to (o	r as a consequence as a	ence of):	61				
Part II. Other eignif	Icant conditions	contributing to	death but not resu	ulting in the un	derlying ceuse gi	ven in Part I.	23b. Die	d tobacco use con	tribute to	the cause of death
							1,2	Yes 2□ No	3 Prob	ably 4 Unknow
							In:	s an autopsy formed? Spection Yes 28 No	ava con of d	re autopsy tindings ilable prior to appletion of cause leath?
25. Was case refer examiner?	red to medical					-	eath (Check only	rone)		
1 yes 2 2 27. Menner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date (Mo on 9-2) be 28e. Place	e of Injury onth, Day Year) 3 - 99 be of Injury - At ho ding, etc. (Specifi	1)	28c. Inju Wo M 1 C	her: 4 Nursing ny et nk? Yes 2 No	28d. Describe House 28f. Location City or T		ed er or Rural 3 C l e	Route Number,
29a. Certifier (Check only one)	1 Certifying F	miner: On the	e best of my know	od Pn / Y wledge, death ion and/or inve	occurred at the ti	me, date end pla opinion, death oc	Baltime ce, end due to the curred at the time	e cause(s) end mai e, date and plece, e	nner as sti	ated. the cause(s)
29b. Signeture and	yst.	1 1	Nac	12,1	10	se number C.M.E.		29d. Date signed SEPTEMBE		
30. Name and addr	ess of person who	completed cal				Baltimor	e. Marv	land 2120	1	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Yeer October PEFPE LINA 31 1999 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 20XF Months 216-29-5571 Yrs. MAR. 8,1902 RUSSIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7920 SCOTTS LEVEL ROAD 21208 RUSSIA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: WHITE Specify. 3 ☑ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent'a Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) JOSEPH TSPIS (UNKNOWN) MARTA 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) GREGORY RODBAN / GRANDSON 2904 TANEY ROAD - BALTIMORE, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriel 2 ☐ Cremation 3 ☐ Removal from State 10/10/99 OWINGS MILLS, MD HAR SINAI CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fallyre. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieled events resulting in death) Lest Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evaileble prior to completion of cause of death? 24e. Was en eutopsy Antinogel poto JERT LA 1 Yes 2 No 1 Yes 2 LNO 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) end manner stated. 29a. Certifier

physician and the bunal-transit The lew requires that the death certificate be executed Box 68760, signed by the e Records, i certificete hes t Division of Vital Hospital or Attending Physician: this After death. rector: / To the Hospital or A within 24 hours efter To the Funeral Direcompletely filled in b

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show a notified at

"natural", or items 23s or adical Examiner must be

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7 is marked other trsumatic event,

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permit. Pages Department of Important: If It any Injury or o

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Certification: To

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Pages 1 and 2 should be filed within 72 hours efter death with nent of Health end Mentel Hygiene.

State Registrar

1999

OR (ANDO 31. Date filed (Month, Dey, Year)

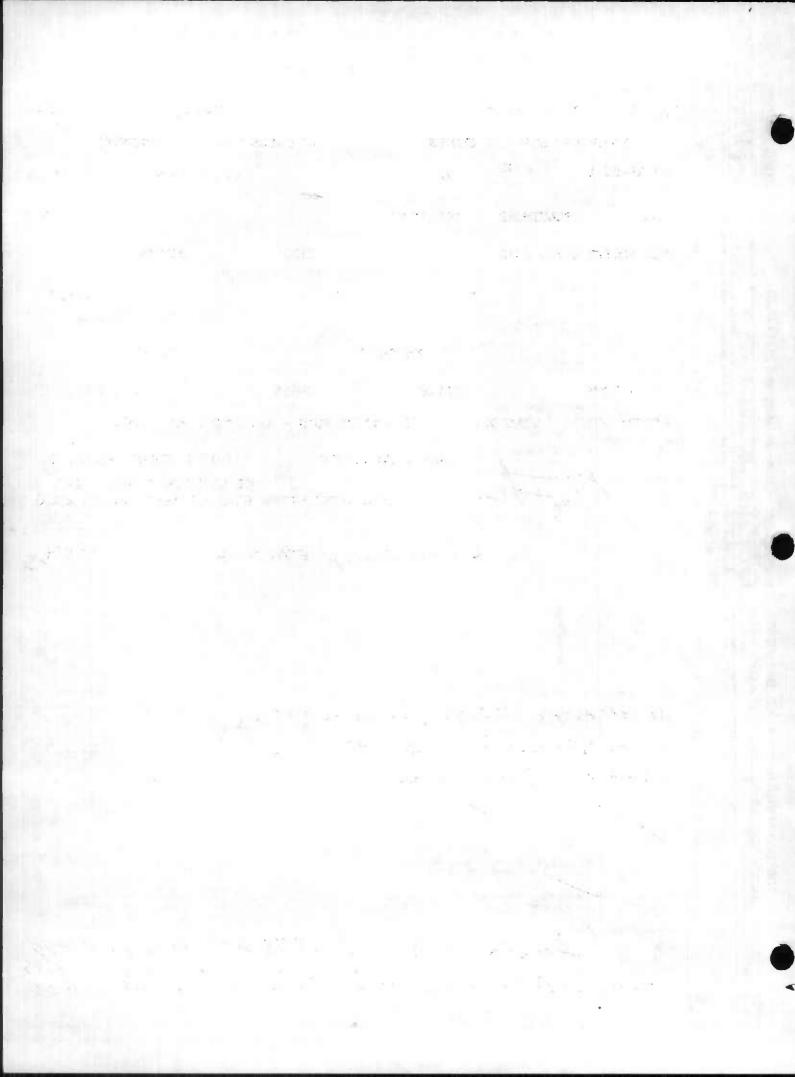
29b. Signeture and title of certifing



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

14 PER F.H. State of Maryland 7 Department of Health and Mental Hygiene AMEND ITEM: # Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month 3. Tima of Death **Physician** WALKER MILLORED OCTOBER 10 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PIDRTINS Home EOR THE STONSVILLE SALTIMALE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 € F 217-09-4763 Director July 11, 1919 Maryland Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 601 Maiden Choice Lane 21228 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Reme : 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) filed within 72 hours after 1 Nevar Married 2 Married 1 Yes 2X No natural, or Baltimore, Maryland 21215-0020 Specify: White 1 Yas 2€ No Specify: by BLACK 3€ Widowed 4 Divorced Year or Datas Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cleaner 6 Maintenance 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filt Department of Heelth and Mentel Hy Important: if Item 27 ta marked oth any Injury or other traumatic avent abcs. Be Augustus Baily Beatrice Harris 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose B. Nelums/ Sister 3602 Liberty Heights Ave. Baltimore, Maryland 21215 20b. Place of Disposition (Name of 20a, Mathod of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cramation 3 Ramoval from Stata 10/12/1999 Baltimore, Maryland Baltimore National Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. sackie 4107 Wilkens Avenue Baltimore, Maryland 21229 Manner 23a. Party Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset end Death **Physician** /Medical Immediata Causa (Final 1 day disaasa or condition resulting in deeth) Examiner Examiner physicien and the burief-transit Sequentially list conditions, if any, laading to immediata cause. Enter Undarlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Box 68760. tendon Physician/Medical Dua to (or as a consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown Records. Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy 1 Yes 2 ₽No 1 Yes 2 TNo Division of Vital 89 25. Wes casa rafarred to medical examinar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 PNaturel 5 Panding invastigetion after death.

Director: After d in by the fur 1 TYes 2 No 2 Accidant 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) in 24 hour. 4 Homicide Hospital 1 Certifying Physician: To tha best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and manner stelled. (Check only one) To the I within 2. 29b. Signature and title of cartified 29c. License number 29d. Dete signed (Month, Day, Year) 021649 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

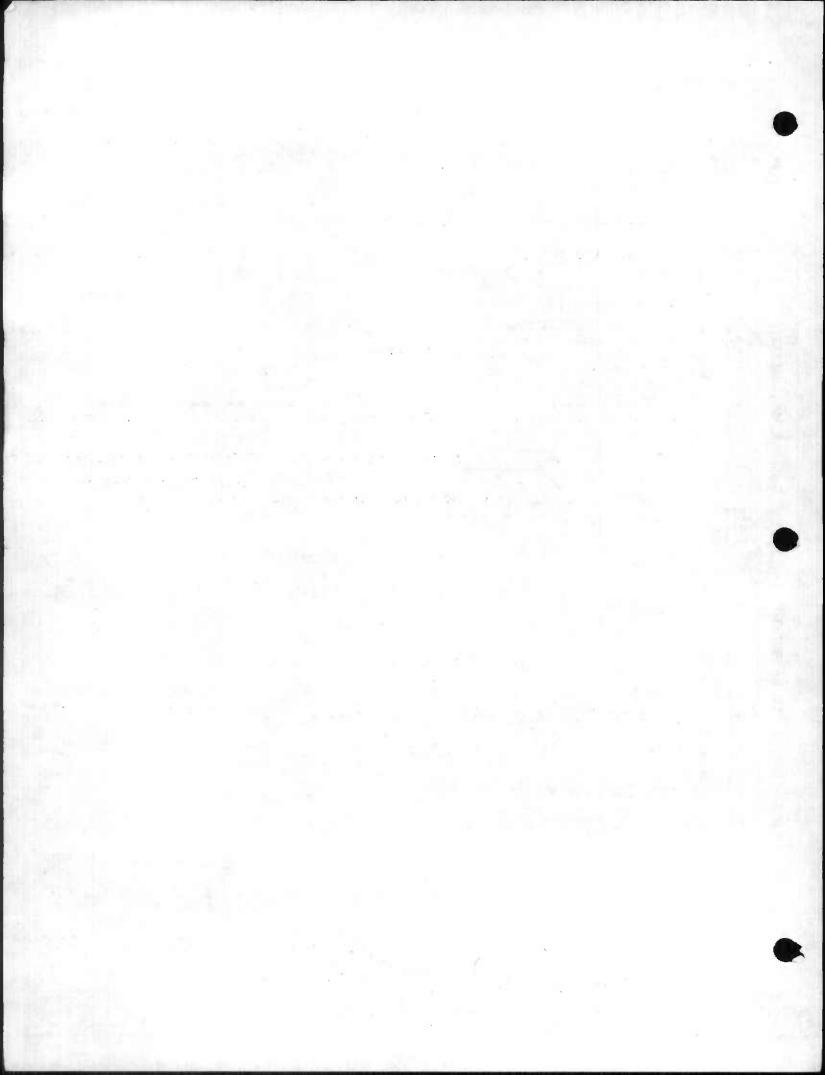
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State Registrar 31. Dete filed (Month, Day, Year)

32. Registrar's Signatura

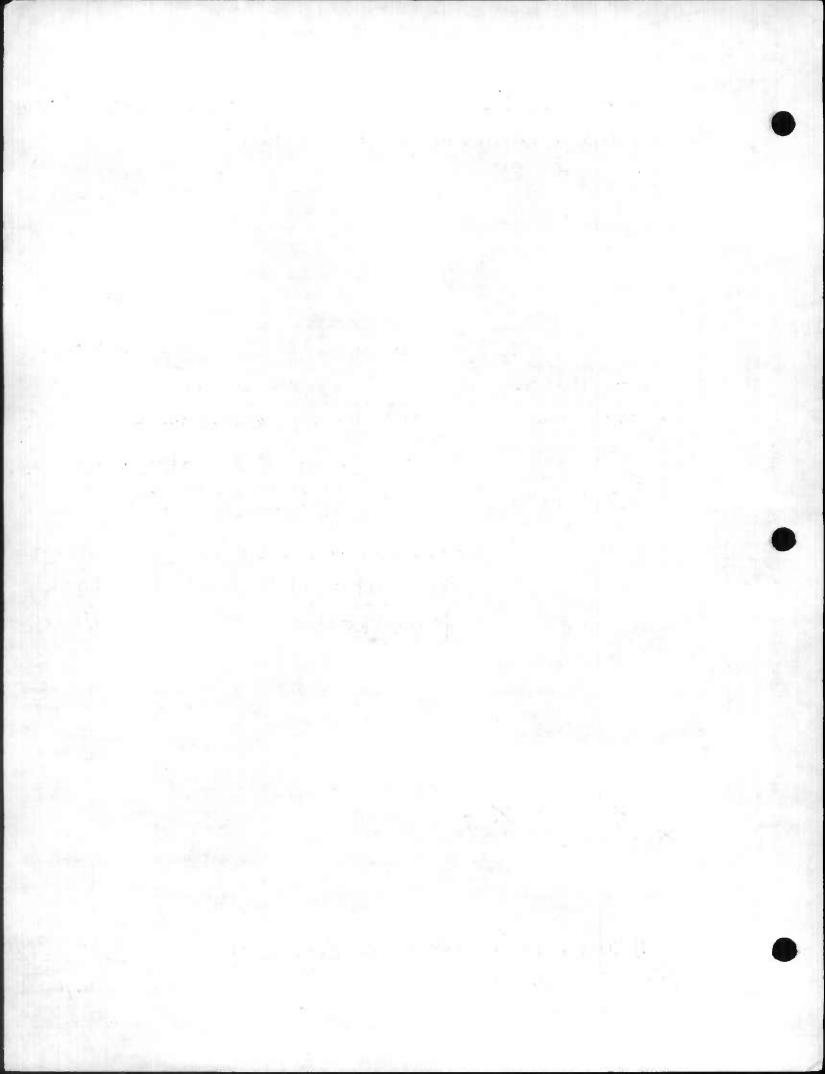
to. Belhouse MO 21229



State of Maryland / Department of Health and Mental Hygiene

			Otato of Mai	•	Certificate of	of Death		eg. No.	9 j	1950
	Physician	1. Decedent's Name (First, Middle, Last	Natts			717	2. Date of Deat Month		igg.	3. Time of Death 7: 05000
	/Medical Examiner	4a Facility Name (If not institution, give JOHNS HODEUS	and the same of th	Medic	ial Cirk	4b. City, Town, or Balh M	Location of Death	4c. County	of Death	
	Funeral Director	5. Social Security Number 6. Se 212–52–7255		In yrs. last birth		ar If Under 24 Hrs	8. Date of Birth	Year) 1949	Count	ace (State or Foreign try) Land
5-0020 72 hours after death with the Maryland natural; or frems 23a or 23a-f show size I Exercited at size Exercited at size by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		0c. City, Town	or Location	Middle	River		10	0d. fnside City Limits 1 ☐ Yes 2 ☑ No	
	23a or 28. mil be not al Direc	10e. Street and Number 104 Cowhide Ci	rcle		10f. Zip Cod	21220	1	0g. Citizen of V USA	What Count	ry?
	ar, or he barries	11. Marital Status 11. Marital Status 12 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 Phoening Yes, Give Year or Dates:	er in U,S.	13. Was Decedent of If Yes, specify C	Specify Yes or No- to Rican, etc.)	Bled	e - America ek, White, e	etc.	
15-0	ygiene. ner than "natural", rt, tre Medical Eus Completed by	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. E	Decedent's Usual Oc Give kind of work do	cupation ne during most of wo ined)	rking	16b. Kind of Bu	usiness/Ind	ustry
2121 within	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		dministrat			Group B	enefi	t Service
Maryland 21215-0020 d 2 should be filed within 72 hours at	Be doth	17. Father's Name (First, Middle, Last) William G Watts			ma (First, Middle, M Andresin:		ne)			
more, Peges 1 an ent of Heal nt: If Heal ry or other	pue e	19a. Informant's Name/Relationship (7) Jean Watts / mother			Mailing Address (Str. 4 Cowhide	eet and Number or R Circle E	ural Route Number Baltimore			Code)
	ont of nt: If Ih	20a. Method of Disposition 1 Buriel 2 Coremetion 3 F 4 Donation 5 Other (Specify)		cemetery	Disposition (Name of crematory or other) Crematory	place)		20c. Location - Baltimo		wn, Stata [Aryland
Baltin permit. Pe Department Important eny Injury		21. Signature of Funeral Service Licens	f Essex							
1	nysician Medical kaminer	23a. Pafi1. Enter the disease or complete shock, or heart failure. List on the limit of the list of th	. <u>C</u>	,	ovascul	ace Ave. Edying, such as cardia Or acc Mdoca	c or respiretory arm	est,		Approximate Interval Between Onset and Deeth 2 weeks
Box 68760, eth certificate be executed	0,0	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last	c	ue to (or as a co	ensequence of):	niA				Month
0 5	ached sched	Part II. Other significant conditions con	ntributing to death but r	not resulting in	the underlying cause	given in Part I.	23b. Did to	V		the cause of death?
Vital Records, P	as been signe 2 should be d pleted by						24a. Was a perform		ava	era autopsy findings ailable prior to repletion of cause death?
E B	s certificate has director, page 2 To Be Comp						1 □ Ye	es 20 No	1	Yes 2 No
of Vita	certific rector	25. Was case referred to medical examiner?	Hospital:			Other	ath (Check only on			
O A		27. Manner of Death	28a. Data of Injury	2 ☐ ER/Outp	ma of 28c. fr	4∐ Nursing I njury at Nork?	dome 5 ☐ Reside)
Afte time	rs after death. al Director: After to the in by the funeral Certification:	Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Suicide 4 Homicide Suicide Pending Investigation 5 Pending Investigati	(Month, Day Y 28a. Place of Injury building, etc. (- At home, fam		☐ Yes 2☐ No	28f. Location (St City or Town		per or Rura	l Route Number,
Hospita	within 24 hours To the Funeral completely filled	29a. Certifier Certifying Physical Constitution (Check only one)	sician: To the best of r ner: On the basis of ex and manner state	remination end/	death occurred at the or investigation, in m	e time, date and place by opinion, death occ	e, and due to the courred at tha time, d	ause(s) and ma ata and place,	annar as st and due to	ated. the cause(s)
To the	within To the comple	29b. Signature and titla of certifier	M Sey	morn	/MO k	ense number	0 2	9d. Date signe	d (Month, I	Day, Year) Tober 1214
7	D	Heather Seymon	ompleted causa of daal	ayvie	iype, Print) WMEDIC	al cente	1990 Balh	Easler	nA	reme
	State Registrar	31. Date filed (Month, Day, Year) OCT 1 3 199	32. Registrar's	Sighature &	. Ana s	61				,
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Richard White OCT 08 1999 8:50 AM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 5633 D Harpers Farm Road Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours N 2 M 2 □ F 140-20-3214 73 Yrs. Director 31, 1926 New Jersey JULY Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23s or 28s-(show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Director MD Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5633 D Harpers Farm Road 21044 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Ø Yes 2 □ No 1 9 4 3 / If Yes, Give Yeer or Detes: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: if item 27 is marked other that any injury or other traumatic avent, the lance. Business Owner Advertising 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Richard White Rose Leinauer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jean B. White/wife 5633 D Harpers Farm Rd. Columbia, MD21044 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial X ☐ Cremetion 3 ☐ Removal from Stete Metro Crematory, Inc. 10/09/99 Baltimore, MD 5 Other (Specify) 21. Signature of Funerel Service Ligenson ²²Cremation Society of Maryland, Inc. Ad Edward gorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. Un only one cause on each line. **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or es a consequença of): Box 68760 Physician/Medical Due to (or as e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No Division of Vital Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? To the Hospital or Attanding P within 24 hours after death.
To the Funeral Director: After I 1 Neturei 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 C Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Cartifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

OCT 13 DHMH 16 Rev 6/95

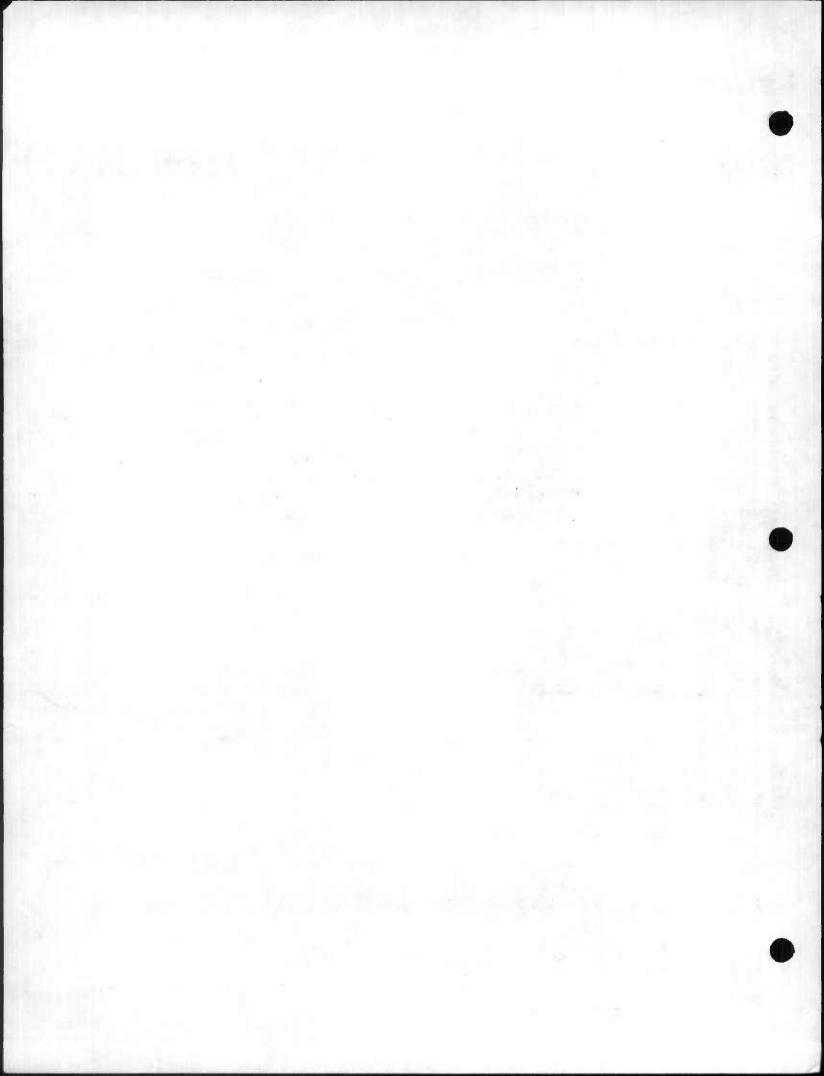
31. Date filed (Month, Day, Year)

2 KNOLL NUICTH 32. Registrer's Signeture 2 person

30. Name and address of purpor who completed cause of deeth (Item 23a) (Type, Print)

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Eduados NO 210

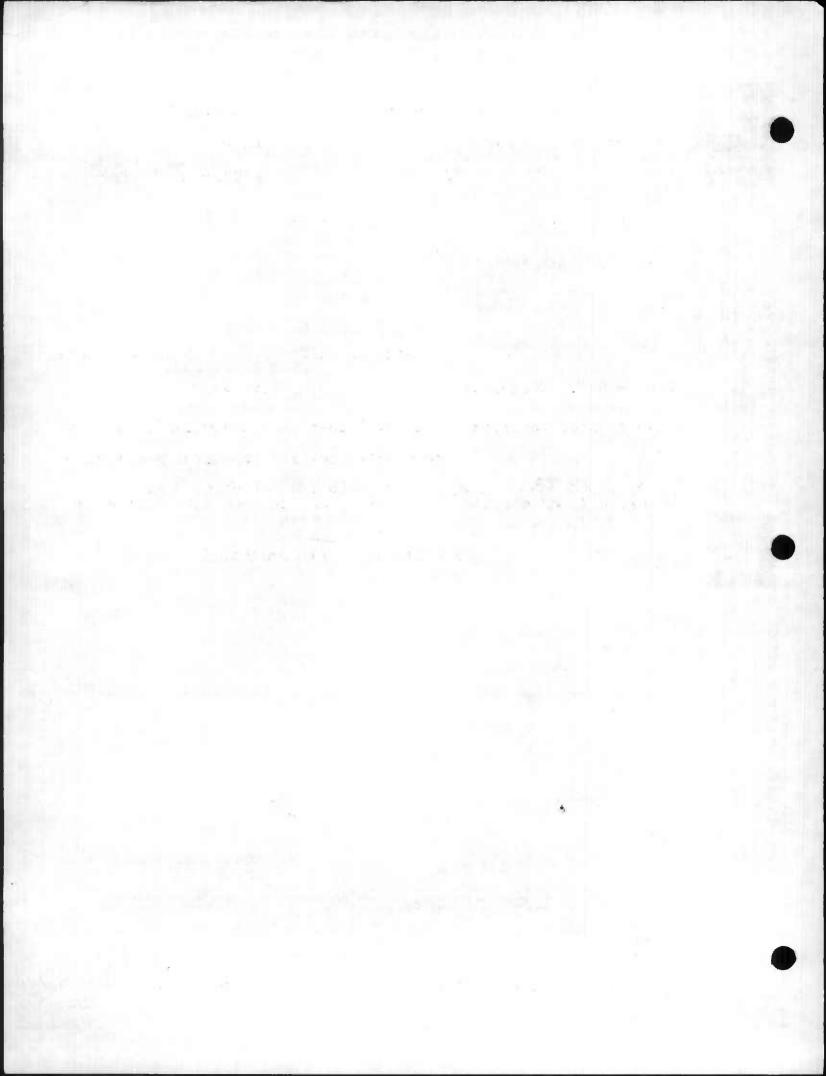


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	Physician	Decedent's Name (First, Middle, I								2. Data of De Month	ath Dey	Yeer	3. Time of Death				
	/Medical		Harold Vi		ets	tone		- Oh T-		Octobe			6:30 AM				
	Examiner	4a Facility Neme (If not institution, g					4			ocation of Deat	4c. County						
		Augsburg Luth 5. Social Security Number 6.		e (In yrs. las	e hirehday	If Under 1	Year	Ba1			the	N/A	lace (State or Foreign				
	Funeral Director	199-07-2315 Usual Rasidence of Decedant	1⊠M 2□F	79	Yrs.		Deys	Hours	Min.	8. Date of Bir (Month, De DEC 8,	y, Yaer) 1919	Penr	oleca (Stete or Foreign ontry) onsylvania				
	Age Age	10a. State 10b. County		10c. City, 7	Town or L	ocation						1	0d. Inside City Limits				
	with the Marylan a or 28a-f show be notified at Director	Maryland N/	' A			Balt	im	ore					1∑ Yas 2□ No				
	vith the Ma t or 28a-f a be notified Director	10e. Street and Number				10f. Zip C	-	010			10g. Citizen of	What Cour	ntry?				
	M Paris	6811 Campfiel	d Road				212	07			II	SA					
	flar death v r flama 23a siner.mast Funeral	11. Maritel Stetus	12. Was Decedant	Evar in U,S.	13.				gin? (Sp	ecify Yas or No Rican, etc.)		e - Americ ck, White,					
0	etter or the mines		Armed Forces? 1 Yes 2 A	No		1 Yes 2		Specify:	, i dello	riioan, etc.,	Specify		eic.				
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5	natu dice	15. Decedent's (Specify only highest of	Educetion rede com <i>pleted)</i>		16a. Dece (Give	edent's Usuel e kind of work DO NOT use	done d	etion during most	of work	ing	16b. Kind of B	usiness/ind	dustry				
Maryland 21215-0020	od within 72 ho ygene. wer than "nature it. the Medical. Completed	Elementary/Secondery (0-12)	College (1-4or	5+)		neran					Luther	an C	hurah				
d 2		17. Fether's Neme (First, Middle, La			Бист	leran	1 a		r's Nem	e (First, Middle	Maidan Suman		Hulch				
an	id be fi ked off ic ever o Be	George Henry		e						e Vink		-/					
J.	merke merke merke merke	19e. Informent's Neme/Reletionship			19b. Meil	ing Address (Street					, City or Town, Stete, Zip Code)					
ž	27 is at 17	Roger A. Whets					Locust Lane New Oxford, PA 1					7350					
re,	E E E	20e. Method of Disposition		20b. Pled	Place of Disposition (Neme of pametery, cremetory, cremetory or other place)						20c. Location	- City or To	own, State				
Ê	permit Pages Department of Important of in	1 Burial 2 □ Cremetion 3 4 □ Donation 5 □ Other (Spec				Hill (V	10/11/9	9 Wayne	esbor	o, PA				
Baltimore,	mir. Martin Injuri	21. Signeture of Funeral Service Lic		*/	2	2. Neme end	Addres	ss of Fecility	v				0, 411				
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		Edward A. 23a. Pert1. Enter tha disease, or co	regorchi.								tonsvi	me,	MD ZIZZ Approximete				
	Physician	shock, or heert failure. List on	ly one cause on each li	ine.									Interval Batwaan Onset end Death				
A.	/Medical	Immediate Ceuse (Finel	C 1	REI	BRI	41	1	LIPA	na s	BOSIS		i					
	Examiner	disease or condition resulting in deeth)	e	Due to (or e				MO	/ 4 / / / / /	70323							
	je je			200 10 (01 0	0 0 001100	, qualita erj.											
	certificate be executed ding physician and use as the buriel-transit wheelcal Examiner	Sequentially list conditions,	b	Due to (or a	s e conse	equence of):											
0		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury										i					
68760	eath certificate be attending physicis for use as the bu	thet initieted events rasulting in death) Last	С.	Due to (or es	s e conse	quence of):											
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Box	attend for us		0									1					
	the a hed f	Part II. Other significant conditions	contributing to deeth b	out not resulting	ng in the	underlying car	usa giv	en in Pert I.		23b. Dld	tobacco use co	ntribute to	o the ceuse of death?				
P.0	requires that the de seen signed by the a chould be deteched									10	Yee 2 No	3□ Pro	bably 4 Onknown				
ds,	O 00 0									044 18/4	elvilleda)	24h W	ere eutopsy findings				
0	The law require sate has been signed 2 should to Completed I										an autopsy ormed?	av	reilabla prior to				
3ec	has by ye 2 s										/	of	death?				
alF	cate ha									10	Yes 200 No	16	☐ Yes 2☐ No				
Vital Records,	certificate rector, peg	25. Was case referred to medical exeminer?	Hospitel:				Oth		of Deel	h (Check only	one)						
of	T digital	1 Yes 2 Mo	1 ☐ Inpatie		NOutpetie			4 LLPNU	rsing Ho		dence 6 Oth how injury occur		<i>'y)</i>				
	leath. lor: After the fune cation	1 Naturel 5 ☐ Pending	(Month, De		Injury	M	c. Injun Worl	k?` Yes 2⊡I	No	200. 0030100	now injury occur						
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Division	in Defe	4 Homicide determine	building, et	c. (Specify)	.,, .	,,				City or To							
		29a. Certifier 1 Certifying F	Phyaician: To the best	of my knowle	dge, dea	th occurred et	the tin	ne, date en	d plece.	end due to the	ceuse(s) end m	enner es s	steted.				
	he Hosp in 24 hou he Fune pletely fil edical		eminer: On the basis o	f examinetion													
	within To the comp	29b. Signature and titla of certifiar	1			29c.	Licans	a number			29d. Data signe	ed (Month,	Dey, Year)				
	->-0	Jacken	- NO00	0101	~	1) 2	850	75		10/8	8/90	7				
	le	30. Name and eddress of person wh	o completed cause of a	deeth (Item 2)	3e) (Tvne	Print)	0		,		1	10	r				
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Registrar DHMH 16 Rev 6/95

OCT 13 1999



State Registrar 31. Dete filed (Month, Day, Year) OCT 1 3 1999

address of person who complated

29b. Signatura and titla of certifian

32. Registrar's Signature

seusa of death (Item 23a) (Type, Print)

within 2

29c. License number

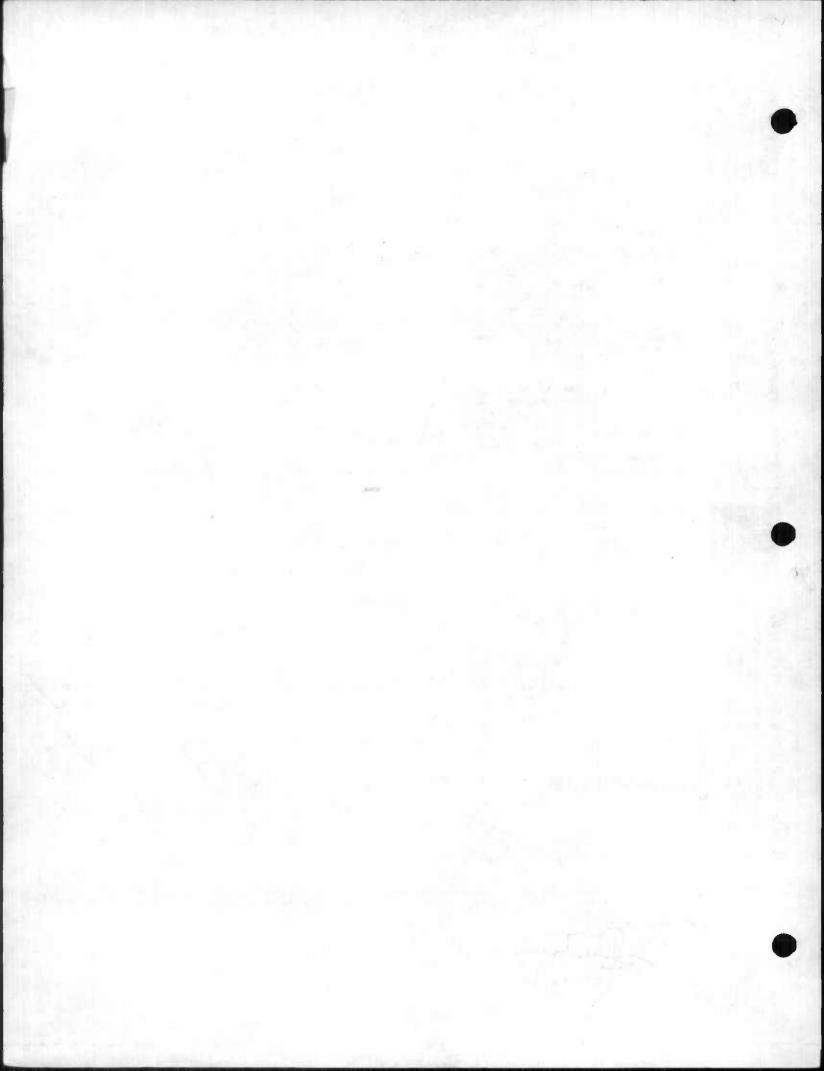
O.C.M.E

eStree(111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

OCT.

7, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth

Physician	
/Medical	
Examiner	

Funeral

Physician /Medical Examiner Hospital or Attending Physician: The lew requires that the death certificate be executed for use as the burial-transit been signed by the a should be detached hes certificate funeral director, After this 24 hours after death. Funeral Director: A completely filled in by To the within 2

Director herra 23a or 28a-f a ner must be notified Directo Funeral filed within 72 hours after Baltimore, Maryland 21215-0020 6 ģ Completed Hygiene. 12 permit. Pages 1 and 2 should be fish Department of Health and Mental Hy Important. If Nem 27 is marked other any injury or other traumatic event. Physician/Medical Examiner P.O. Box 68760. Division of Vital Records. Be Completed by Medical Certification: To 4 Homicide

1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 10 2:30am George E. Worthen, Sr. 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Baltimore 3701 North Point Road n/a If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign PA 5. Social Security Number 7. Age (In yrs. last birthday) Days 15√M 2□ F Yrs. 278-18-1023 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3701 North Point Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 NWW 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Maryland Drydock Supervisor 17. Father'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willa Sylvestra Honaker Elden Worthen 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 North Point Road, Baltimore, MD 21222 Maria Worthen 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10-9-99 Baltimore, MD Dulaney Valley 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility
Kaczorowski Funeral Home MD 21222 1201 Dundalk Avenue, Baltimore, Approximete Intervel Between Onset end Death omplications that caused the Do not enter the mode of dying, such ea cerdiac or respiretory arrest, stive heart failiere Immediate Ceuse (Final diseeae or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

bestos exposure

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

October 8

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27, Menner of Death 28c. Injury et Work? 28d. Deacribe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of

5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

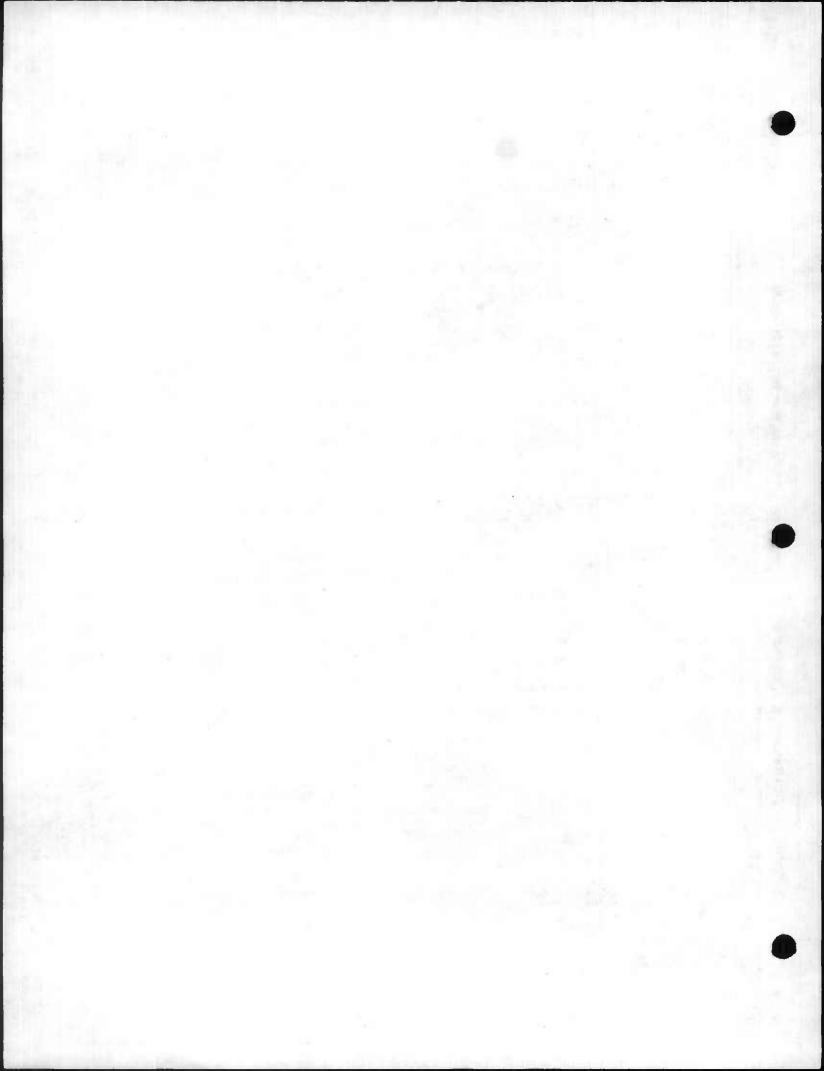
29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as atated.

(Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

30. Name and address of person who o Mem 23a) (Type (Print) 202. I. Mallony, salfinine 31. Dete filed (Month, Day, Year)

State Registrar

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** Frank Williams 3244 -John OHEMPOR /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Hospital 100 N. Broadway hurch Bastimore MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) -0 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** ところと 10M 20 F Months 163364052 51 Yrs. Director LINKHOWN 10/29/4 Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours efter death with tha Marylar Department of Haath and Mental Hygiena. Important: If Item 27 Ia marked other than "naturel", or Itema 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinar must be notified. 15 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? tomeless 21202 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 11nknown 1 ☐ Yes 2 No If Yes, Give Year or Datas: 1 Never Merried 2 Merried hr trank 1 ☐ Yes 2 ☑ No Specify: Specify: BLack by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) unknown unknown none 17. Fathar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be John Williams 2 unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) unknown unknown 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20e. Mathod of Disposition Dete cematery, cremetory or other piece) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4 □ Donetion 5 ☑ Other (Specify) in State 21. Signature of Fungral Service Licensee 22. Neme end Address of Fecility Ronald S Let & State Anatomy Board, 655 W. Baltimore Street rector 23a. Part Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, monic The law requires that the death cartificate be Physician/Medical Due to (or es a consequence of): no been signed by the a should be detached t Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the call 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 26 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificata To the Hospital or Attending Physicien: within 24 hours aftar death. To the Funeral Director: Aftar this certifics 25. Wes case referred to medical exeminer? Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 10 funeral 27. Manney of Deeth Certification: Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Deturel 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, fermy street, factory, office building, etc. (Specify) 4 Homicide N 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. edicai Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and menner steted. (Check only 29b. Signativ 29c. License number

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DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

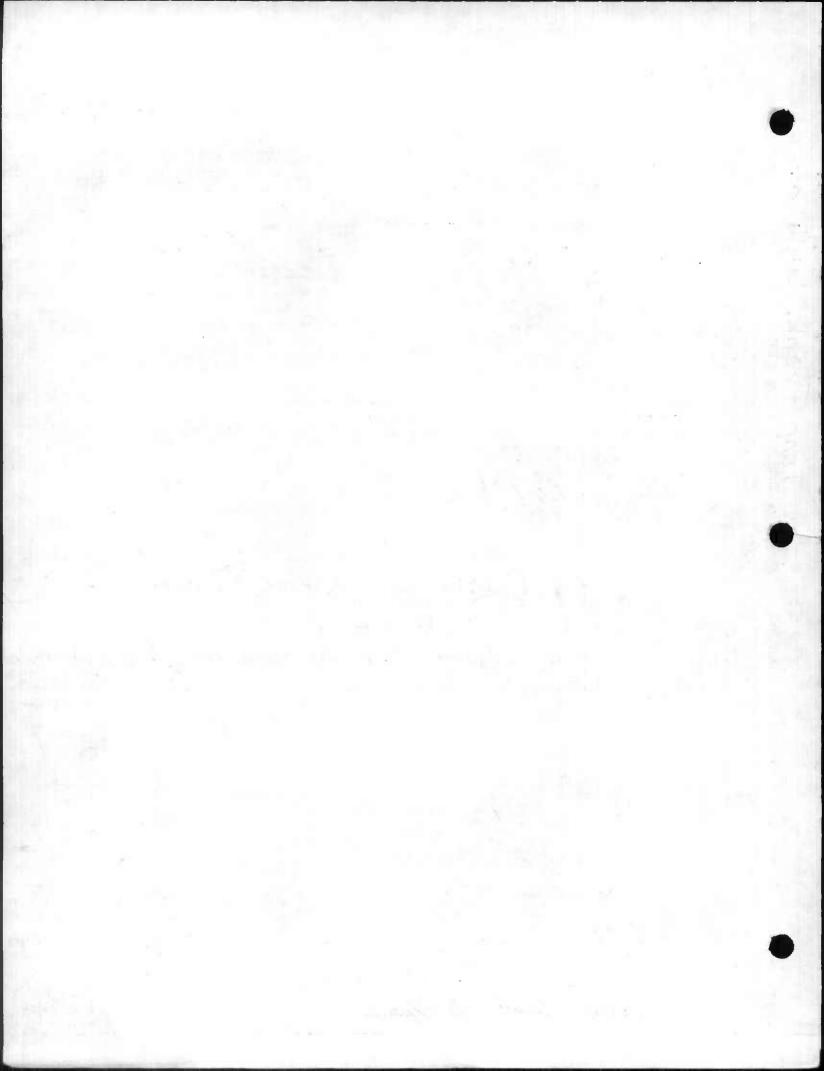
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impleted cause of death (Item/23a) (Type, Print)

32. Registrer's Signature

DERICA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death **Physician** ELYCE WASSERMAN 2//2 October /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE N/A If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) DEC - 7, 1929 Birthplace (State or Foreign Country) **Funeral** Days Montha Hours 1 M 20 F 69 Yrs. 216-24-2192 MD Director Usual Residence of Deceden the Maryland 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f show MD BALTIMORE 1 ☐ Yes 2 ☑ No Director RANDALLSTOWN 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 8908 ALLENSWOOD ROAD 21133 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Bleck, White, atc. should be filed within 72 hours after on Mental Hygiene.
marked other than "natural", or he 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: WHITE Specify: p 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLAIMS EXAMINER SOCIAL SECURITY ADMIN. Baltimore, Maryland 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Peges 1 and 2 should be 1 nent of Health and Mental I int: If item 27 le marked of MEYER DICKMAN SARAH LEVIN 19a. tnformant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) GLENN WASSERMAN / SON 47-507 KINANA WAY - KANE ONE, HAWAII 96744 other t 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Department of Important: If it any injury or o Purial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Specify) BETH JACOB ANSHE VESHEAR 10/10/99 ROSEDALE, MD 22. Name and Address of Fecility 21. Signature of Funny SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 disease, of complications that caused the deeth. Do not enter the mode of dying, such ea cardiac or respiratory arrest, milure. List only one cause on each line. 23a. Part1. Enter the Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a the buris Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 42 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 2 NO 1 Yes 25 No Be 26. Place of Death (Check only one)

Box 68760 To 100 ö Certification: Division after deat Director:

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e Funeral D Metaly Illed

To the P within 2 To the 9

Medical

25. Wes case referred to medical examiner?

1 Yes 2 No 27. Manner of Death 5 Pending

investigation 2 Accident 6 Could not be 3 Suicide 4 ☐ Homicide

Hospital: 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

[In the dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner steted.

28f. Location (Street end Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifie

29a. Certifier

29c. License number

28c. Injury at Work?

1 Tyes 2 No

29d. Date aigned (Month, Day, Year)

d cause of deeth (Item 23a) (Type, Print)

32. Registar's Signeture 1999

Belvedere Ave Ba

State Registrar

DHMH 16 Rev 6/95

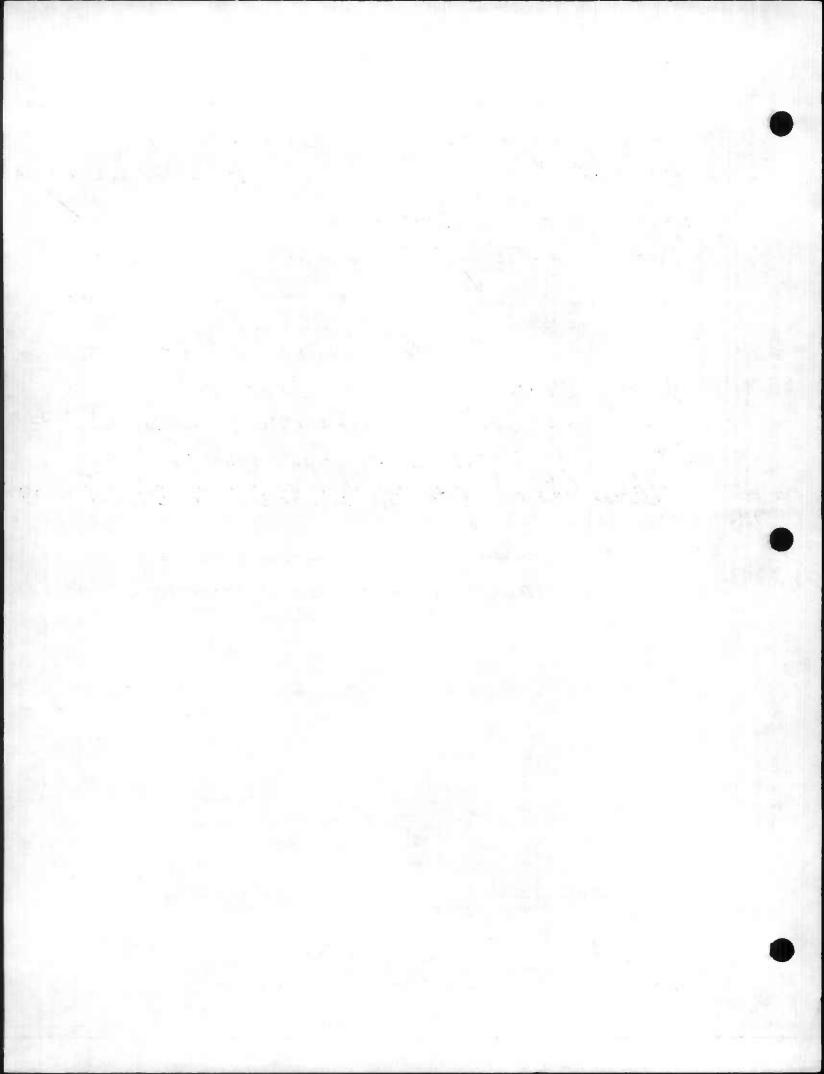
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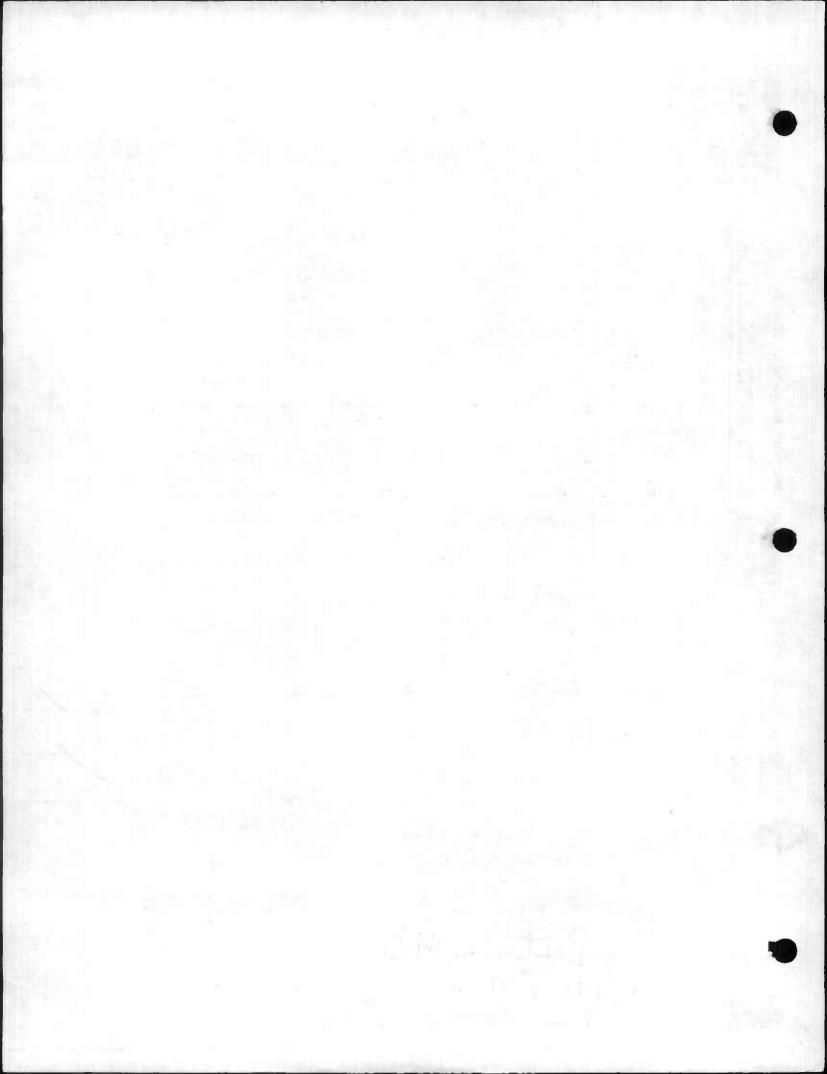
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	State of Maryland	Certificate of Death	Reg. No.	31958
	1. Decedent's Neme (First, Middle, Last)		2. Date of Death	3. Time of Death
Physician /Medical	1/		SEPTEMBER 29	
Examiner	4e Eacility Name (If not institution, give street end number)	4b. City, Town, or	Location of Death 4c. County of	Peath
	5. Social Security Number 6. Sex 7 7. Age (In yrs. last	hirthday) If Under 1 Year If Under 24 Hrs	IMORE N/	<i>ft</i>
Funeral Director	5. Social Security Number 6. Sex 10 F 7. Age (In yrs. last Usual Residence of Decedent	Yrs. Months Days Hours Min		9. Birthplace (State or Egraign Country) AROLINA
the Maryland 28s-f show nothing at	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	own or Location MORE		10d. Inside City Limits 1 ■ Yes 2 □ No
£ 5 6	100. Street and Number 1804 F FAUETHE STREET	et 101. Zip Code	10g. Citizen of Wi	net Country?
of thems		13. Wes Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puer 1 Yes 2 Tho Specify:	Specify Yes or No- to Rican, etc.) 14. Race Bleck, Specify:	- American Indien, White, etc.
1 21215-0020 ed within 72 hours af order or than "natural", or the Modes Evan Completed by F	15. Decedent's Education	6a. Decedent's Usual Occupation	16b. Kind of Bus	iness/Industry
	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)		. / 0
d 212 filed with Hygiene, the ont, me	6	TRUCK DRIVER	Const.	
yland ould be fill Mental H merked oth etic even	17. Fether's Neme (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maiden Sumeme,)
Maryland 2 d 2 should be filled th and Mental Hygi T la marked other traumatic event, T o Be Co		9b. Mailing Address (Street and Number or R	hural Route Number of the or Town S	Vata Zin Code)
2 2 2 2	ALISA WEATHERS	1804 F. Courte	St /SAHA	md. 2123 1
other tr	20e. Method of Disposition 20b. Plece	e of Disposition (Name of etery, cremetory or other place)	Date 20c. Location - C	city or Town, State
	1 Burial 2 Cremetion 3 Removel from State 4 Denation 5 Other (Specify)	Zion Cemetery	iolaha BATA	md.
Baltimo	21. Signature of Funeral Service Licensee	22. Name and Address of Macility	TO Et	1 PA
Ball Department of the part is part in	Illera adams fores	MAN Edmonds	Aug BAN	ma 21229
	23a. Part1. Enter the diseese, or complications that caused the deeth. I shock, or heart failure. List only one cause on each ine.	Do not enter the mode of dying, such as cardia	c or respiratory errest,	Approximete Intervel Between
Physician				Onset end Deeth
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	TRUCTIVE PULMONA	RY DISEASE	
ja ja	Due to (or as	a consequence of):	2011	
owcuted in and intransit Examiner	b. ARRITY TUN	e consequence of:	13KILLATION	
oxec oxec In an an an an an an an an an an an an an	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e consequence ory.		
68760, ficate be executed in physician and is the burial-transit edical Examir	thet initieted events	e consequence of):		
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death certification of the strenging of for use assistan/Me	d.			
. 0 6 2 2	Part It. Other significant conditions contributing to death but not resulting	g In the underlying cause given in Pert i.		ribute to the cause of death?
			1 ☐ Yea 2 ☐ No	3 Probably 4 ☑ Unknown
Records, P.O. he law requires that the has been signed by things 2 should be deteched by Physem propleted by Physem prop			24a. Wes an autopsy	24b. Were autopsy findings
law require as been si 2 should be a shoul			performed?	available prior to completion of cause of deeth?
The law requirements been single has been single because by page 2 should Completed			1□Yes 2☑No	1 Yes 2 No
f Vital Raystelen: The I securificate had director, page		26. Place of De	eath (Check only one)	
	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/		Home 5 ☐ Residence 6 ☐ Other	(Specify)
ng Pl	27. Menner of Death 1	b. Time of tnjury et Work?	28d. Describe how injury occurre	d
Division of standing P as after death. The Director: After to a Directo	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	0011	S 1 S 1 1 1
or An after of An in by	4 Homicide determined 28e. Plece of Injury - At home building, etc. (Specify)	, term, street, fectory, office	28f. Location (Street end Number City or Town, State)	r or Hurel Houte Number,
potal ours ours filled		Ice, death occurred at the time, date and place	e, and due to the cause(s) and man	ner as stated
Division o To the Hospital or Attending Ph within 24 hours after death completely filled in by the funeral Medical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination end menner steted.	and/or investigation, in my opinion, death occ	urred at the time, date and place, ar	nd due to the cause(s)
To the To the comp	29b. Signeture and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
	1 (> 000	052290	Y SEPTEM	BEN 29, 1999
\	30. Name and address of person who completed cause of deeth (Item 23)		- 7 :	
	100 N. BROADWAY, Brut	imore mo 21	レン	
State Registrar	31. Date filed (Month, Dey, Year) OCT 13 1999 32. Registrer's Signature	B. Sparks		
DHMH 16 Rev 6/95	10 1000	p. sparks		
Com setta i ilmi-m		and the second s		



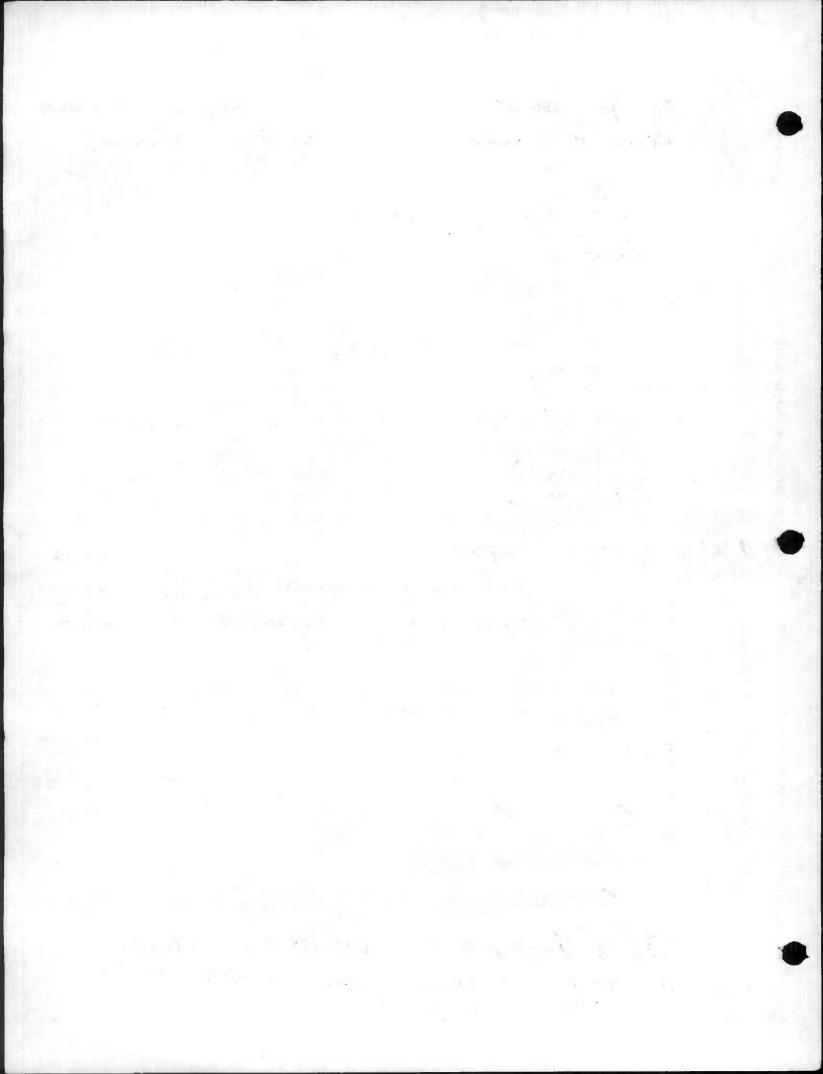
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WASHI	NGTON AMEND			ART I	, Čer	tificate of	Death				J	1957	
hysician /Medical	1. Decedent's Name (Firs	1 /	Sylvest	ter	Was	shinat	00		Date of De Month OCT •	Day 6, 1999	Year	3. Time of Death	
xaminer	4a Facility Name (If not in						4b. City, Tox			h 4c. County	of Death		i
	JOHN HOPK					Williaday 4 Vana		'IMORE		NA			
al or	5. Social Security Number 2 4-58-95 Usual Residence of Dece	72 15	X 7. Ag	pe (In yrs. la:	st birthday) Yrs.	Months Days	If Under :	Min.	Dete of Bir (Month, Da Aug. 1	th ay, <i>Year)</i> .6, 1952	9. Birthp Coun	lace (Stete or Foreign try) [d •	
rector		County		10c. City,	Town or Lo	ation					1	Od. Inside City Limits	
ō	Md.	n/a			Ba1	timore						XX Yes 2 □ No	
al Director	10e. Street and Number 1819 Spring	g Stree	t			10f. Zip Code		eri:		10g. Citizen of USA	What Coun	try?	
by Funeral	11. Marital Status XXX Never Married 2 3 Widowed 4 D		12. Wes Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates;		H	/es Decedent of I- Yes, specify Cub	tispanic Orig an, Mexican Specify:	gin? (Specif , Puerto Ric	y Yes or No an, etc.)	Bla	ck, White, or Bla	etc.	-
Completed		ecedent's Edu y highest grad (0-12)		5+)	(Give I	ent's Usuel Occup ind of work done O NOT use retire	during most	of working		16b. Kind of B	usiness/Inc	dustry	
	17. Father's Name (First,	Middle Last)			, •		18. Mothe	r's Name /F	irst. Middle	, Maiden Surnan	ne)		1
0	Booker T. V	Washing						Mae V					
	Joseph & Ru	olationship (7) oth Ebo	מייו			Address (Street Elkader						Code)	
	20a. Method of Disposition **DefBurial 2 Crer 4 Donation 5 0	metion 3 🗆 F	Removel from Stata	20b. Ple- cen	ce of Disponentery, crem	ition (Name of etory or other ple Cemetery	ce)		Date	20c. Location - Baltimo	City or To		
	21. Signature of Funeral S	Service Licens	66 A	Q	25	Name and Addre	ss of Fecility	Nutte	er Fur VY Bal	eral Ho	mes, Md.	Inc. 21216	
an al er	23a. Part1. Enter the disc shock, or heart failur Immediate Cause (Finat disease or condition resulting in death)	re. List only o		OTIC		ETHANOI					1 1 1 1 1 1	Approximete tritarval Between Onset and Death	
n/Medical Examine	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s, lite	b c	Due to (or e	es a conseques e consequ								
Physician/M	Part II. Other significant of	conditions cor	ntributing to death b	ut not resulti	ing in the un	deriving cause giv	ven in Pert I.		23b. Did	tobacco use co	ntribute to	the cause of dath?	
by Phys									10	Yes 2□No	3 Prol	bebly 48 Unknown	
Completed b										es 2 No	oo of	are autopsy lindings aliable prior to impletion if cause death?	
8	25. Was case referred to examiner?	-	An ancient			1		of Death (C	Check only	one)			1
on: To	X1X Yes 2 No 27. Manner of Death 1 Natural 5 □	Pending	26a. Date of Inju	y Year)	R/Outpatient 8b. Time of F dailys) C	. P 28c. Inju	ry at rk?	280	d. Describe	idence 6 Oth		y)	
Certification:	2 Accident 3 Suicide 4 Homicide	Could not be determined	10-6- 28e. Place of thi	ury - At hom c. (Specify)	2:00 ie, ferm, stre	et, fectory, office	Yes 2☐N	281		(Street and Num wn, Stete)		MACAROLII	Y
edical Ce			sician: To the best oner: On the basis of	of my knowle	edge, death		ma, data and	d place, and		cause(s) and m	annar as si		
Med	290. Signature and title of		and manner str	ated.	NA	29c. Licens				29d. Date signe	d (Month,	Day, Year)	
	30. Name and address of	person who oo	impleted cause of d	leath (tem 2		Print) 1 Street	R=14	imor	Mar				
tate	31. Date filed (Month) Day	Year)		ar's Signatur		Sporks		THOTE	, PIGIL	y Laiki Z	1201		-
istrar	0011	3 1999	1 street		10.	-ye-							

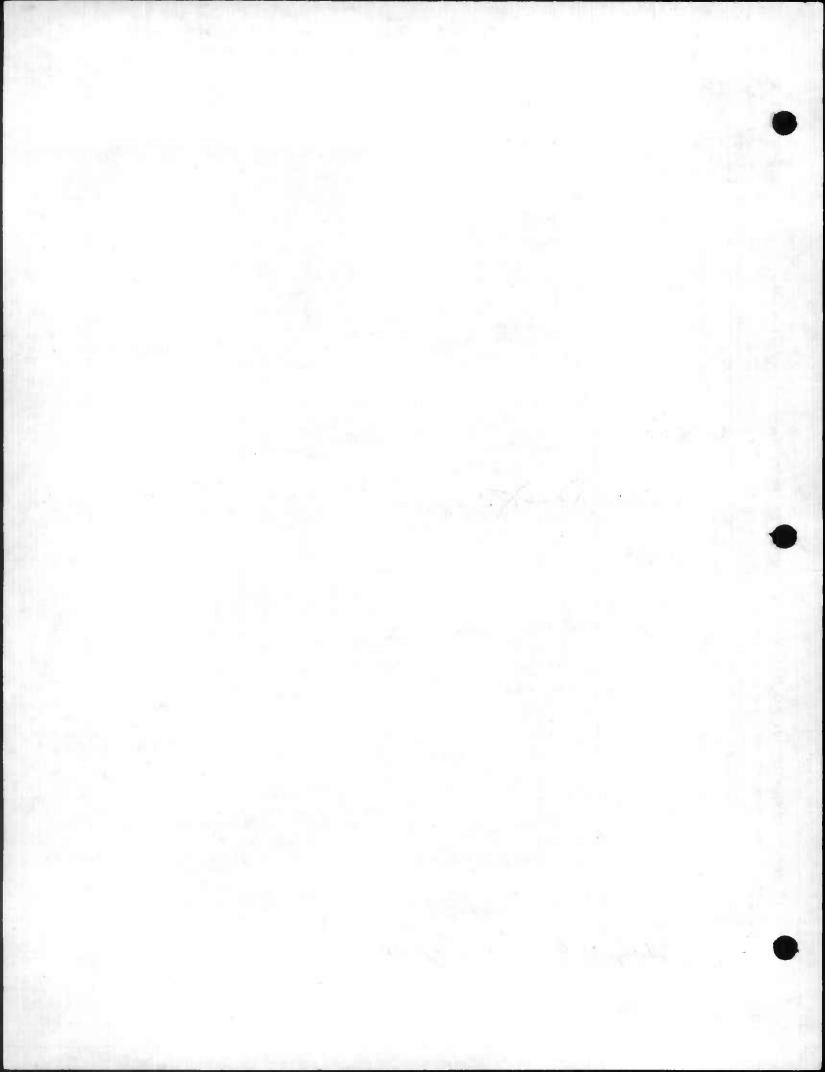


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				State of Maryland /	Department of Certificate of		Hygiene Reg. No.	31959
	Physic /Medi Examir	cal	Deevs Head 1. Decedent's Neme (First, Middle, Lest, Roselyn W. 4e. Feoliity Name (If not institution, giva Deevs Head.) 1. Deevs Head.	lei sey		2. Detect Month Coch 4b. City, Town, or Location of I	ber 10 199	9 4: 45 a.m
	Funeral Director		5. Social Security Number 6. Sec. 265-44-6750		Yrs. If Under 1 Yaer Months Days		of Birth h, Day, Year) 9. I 2 1935 N	Birthpleca (State or Foreign Country) NEW YORK
	e Maryland	Director	10e. State 10b. County Maryland Anne Aru		wn or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	it th	Dire	10e. Street end Number		10f. Zip Code		10g. Citizen of What	Country?
	ath w		8358 Sycamore Road		2110		USA	
020	72 hours after death with the Maryland "natural", or items 23s or 28s-f show potest Examiner must be notified at	by Funeral	11. Maritel Status 1 Nevar Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates:	13. Was Dacedent of If Yes, specify Cub	Hispenic Orlgin? (Specify Yes o an, Mexican, Puerto Rican, atc Specify:	or No- 14. Race - A Black, W Specify: W	
21215-0020	within sna. than "	Completed	15. Decadent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire Cafteria Wor	during most of working ad)	16b. Kind of Busine	
	H H	Be Co	17. Fether's Neme (First, Middle, Last)		carteria wor	18. Mother's Neme (First, Mi		
/lar	should be nd Mental marked o	To B	Edward Dudley			Helen Bake	r	
Maryland	C/ 42 20 40		19e. Informent's Neme/Reletionship (Ty			t end Number or Rurel Route N	•	
	s 1 and f Health ttem 27 other tr		Parnela E. Hartlove		324/ Baltimo of Disposition (Name of	re & Annapolis		
Baltimore,	8 = 5		1X Burial 2 ☐ Cremation 3 ☐ R	emoval from Stete	ary, cremetory or other ple	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20c. Location - City	
Ħ	artmer artmot artmot: Injury		4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Donesia		Haven Cemet		7 Glen Burni	ie, MD.
B	Dep June		12.00	" /)	3111 Mou	ess of Fecility Stalling ntain RD, Pasa	ys runeral H dena MD 21	ome, P.A.
	_		23a. Part1. Enter the disease, or compl shock, or heart feilule. List only of	cations that causad the deeth. Do				Approximata
	Physician /Medical Examiner		Immediate Ceusa (Finel disease or condition	Sepsis				Intervel Between Onset end Death
	LAdimiei	1	resulting In deeth)		consequenca of):	seas dusto	diabetic	21.000
	uted	Examiner	_ b	End stage	renal di	sees neph	ropathy	teb 1999
o,	ate be asscuted sysician and he bunal-transit	Еха	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Stage TV decut	consequence of):	& unhealed @	LOG SHIMO	man the
Box 68760,	that the death certificate be ed by the attending physici detached for use as the bu	Physician/Medical	Cause (Diseese or Injury that Initiated events resulting in deeth) Last	Dua to (or as a	consequenca of):			In the state of th
0	the all	ysic	Pert II. Other significent conditions con				Did tobacco use contribu	ute to the cause of death?
P.O.	that the ed by detac		Diabetes melli	tas, Hypert	PPS,ON)		1 Yes 2 1 No 3	Probably 4 Unknown
Division of Vital Records,	The law requires that the death certifica ite has been signed by the attending phy page 2 should be detached for use as th	Completed by	Cononary arte	y disease	Hyperti pide	240. Y	Wes en eutopsy 24l performed?	b. Were autopsy findings eveilebla prior to completion of cause of deeth?
<u>e</u>	cate h						1 Yas 2 10	1 ☐ Yes 2 ☐ No
<u> </u>	Attending Physician: The law is death. ector: After this certificate has by the funeral director, page 2 s	o Be	25. Wes case referred to medical exeminer?	ospitel:	Ott	28. Placa of Deeth (Check o	, , , , , , , , , , , , , , , , , , , ,	
ō	alc alc	-	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatiant 2 LI ER/O	ulpatient 3L DOA	4 LI Nursing Home 5 LI	Residence 6 Other (S) ribe how Injury occurred	pecify)
o	ath. r: Afte e fune	atlor	1		Injury Wo	rk? Yes 2 □ No	To now injury occasion	
Divis	E Di at o	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injury - At home, for building, etc. (Specify)	erm, street, fectory, office		on (Street and Number or Town, State)	Rural Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edical	29a. Certifler (Check only one) 1 Certifying Phys	Ician: To the best of my knowledger: On the basis of examinetion er end menner steted.	e, deeth occurred et the tind/or investigation, in my o	me, dete end plece, end due to opinion, deeth occurred et the ti	the ceuse(s) end menner me, dete end piece, end d	es stated. lue to the ceuse(s)
	To the Com	Σ	29b. Signeture and title of certifier		29c. Licans	- 0	29d. Date signed (Mo	
1	10		Jy & Su	oup. M.D.	D16	003	10/10/9	7
	10		30. Neme and eddress of person who con Deer's Head Cent	npieted cause of deeth (Item 23e)	(Type, Print) Salisbut	4, MD 2180	2-2018	
	Sta Registra	1	31. Dete filed (Month, Day, Year) OCT 13 1999	3. Registrer's Signature	. Sporks	1		



mn	-5976-02 mr cqueline AMEND I		Type or Print if State of Mary I, II, 27						ble.	160
	Physician	1. Decedent's Neme (First, Middle, Las					2. Date of De	r 5, 199		ne of Death
	/Medical	Jacqueline Maure 4e Facility Name (If not institution, give				4h City Town	or Location of Deat			56 a.m.
	Examiner	11877 New Countr				Columb		Howar		
	Funeral Director	5. Sociel Security Number 6. S 269-42-3382	ex 7. Age (In	yrs. last birtho	Months [rs. 8. Date of Bir		9. Birthplace (S Country) MA	tete or Foreign
	l lu	Usual Residence of Decedent 10e. Stete 10b. County	10	c. City, Town o	or Location				10d. Insi	de City Limits
	Maryland a-f show filed at	MD Ho	ward	Col	umbia Ma	ryland			10	Yes XXNo
	ther death with the Maryla factor thems 23s or 28s-1 sho siner must be notified at Funeral Director	10e. Street and Number 11877 New Country	y Lane		10f. Zip C	210 ⁴	14	10g. Citizen of V	What Country? Jnited S	tates
020	ors after des st., or items Examiner.m by Fune	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Detes:	in U,S.	13. Wes Deceder If Yes, specify 1 \(\subseteq Yes \) 2X	t of Hispanic Origin? Cuban, Mexican, Pu IMo Specify:	(Specify Yes or No erto Rican, etc.)	14. Race Blace Specify	e - American India k, White, etc.	ite
121	led within 72 ho ygiene. wer than "naturn it, the Medical Completed	15. Decedent's Ed (Specify only highest gra Elementery/Secondery (0-12) 12		(C	fe. DO NOT use	done during most of v		16b. Kind of Bu		Human &Service
an	Avertal Hyginarial Hyginarial Event, 1	17. Father's Name (First, Middle, Last)					leme (First, Middle cella Ma		Θ)	
Mary	and 2 sh sallh and 1 27 is m er traum	19e. Informent's Neme/Relationship (1 Stella Yacher / I			Meiling Address (S 055 SR 1	Street and Number or 64 Leetor		er, City or Town, 44431	State, Zip Code)	
0	Pages 1 ar sent of Hea int: If Rem: ary or othe	20e. Method of Disposition 1 Burial 2 Cremation 3 4 Onetion 5 Other (Specific	Removel from Stete	Ob. Plece of D cemetery, Tod Cer	isposition (Name crematory or othe netery	of orplace) October 9,	Date 1999	20c. Location - Youngsto	City or Town, Ste	ite
Balti	Departm Departm Importa any Inju	21. Signeture of Funerel Service Licen		oda, Jr.	Charles	Address of Facility L. Stever st Fort Av	ns Funera Venue, Ba	1 Home, 1timore	Inc.	d 21230
	Physician /Medical Examiner	23a. Part1. Enter the disease, or compands, or heef teilure. List only Immediate Ceuse (Finel disease or condition resulting in deeth)				of dying, such es card		rrest,	Interve	ximate al Between and Death
Ļ.	<u> </u>		Due	to (or es e coi	nsequenca of):					
2	death certificate be executed e attending physician and of for use as the burial-transit siclaryMedical Examiner	if any, leeding to immediate cause. Enter Underlying	c	to (or es a cor	nsequence of):					
X Q Q	ending r use		d							
7. O	y the iched	Pert II. Other algorificant conditions of HYPERTENSION	ontributing to death but no	at resulting in th	ne underlying cau	se given in Pert I.		tobacco use co Yes 2 No	atribute to the ca	Str - Control
Hecords,	been s should							an autopsy ormed?	24b. Were auto available completio of death?	opsy findings prior to n of cause
I	0 - 5 -						120	Yes 2□No	16TYes	2 No
	ystclen: The secrificate director, pag	25. Was case referred to medical examiner?				26. Place of E	Deeth (Check only	one)		
> -	this ce al dire	1XXYes 2 No	Hospitel: 1 ☐ Inpatient	2 ER/Outpe	atient 3 DOA		Home 5 Resi	dence 6 Oth	er (Specify)	
DIVISION OF	on When	27. Menner of Deeth 1 Netural 5 Pending 2 Accident investigation		ar) 28b. Tim Inju	ne of 28c	Injury et Work? 1 Yes 2 No	28d. Describe	how injury occur	red	
	Labor T	3 Suicide 6 Could not be determined	building, etc. (S	pecify)			City or To			Number,
:	within 24 hours at To the Funeral Di completely filled it		ysician: To the best of my niner: On the basis of exe and menner steted.							use(s)
	within To the compl	29b. Signeture end title of certifier	Λ		29c. L	icense number		29d. Date signe	d (Month, Day, Yo	ear)
		30. Name end address of person who	VLoo	(Hapr 23a) (Tu	MP O.	C.M.E.		October	6, 1999	
		Stephen S.	Radentz			Street,	Ral timo~	Maw.l	and 2120	11
	State Registrar	31. Dete filed (Month, Dey, Year) OCT 13 199	32. Registrer's S		Sport	4	DOLLUNDE	e, rotyl	GIRT - 212(



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** HARRY H. OCTOBER 9 1999 ZIMMERMAN 10:15 am /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner ROSEDALE

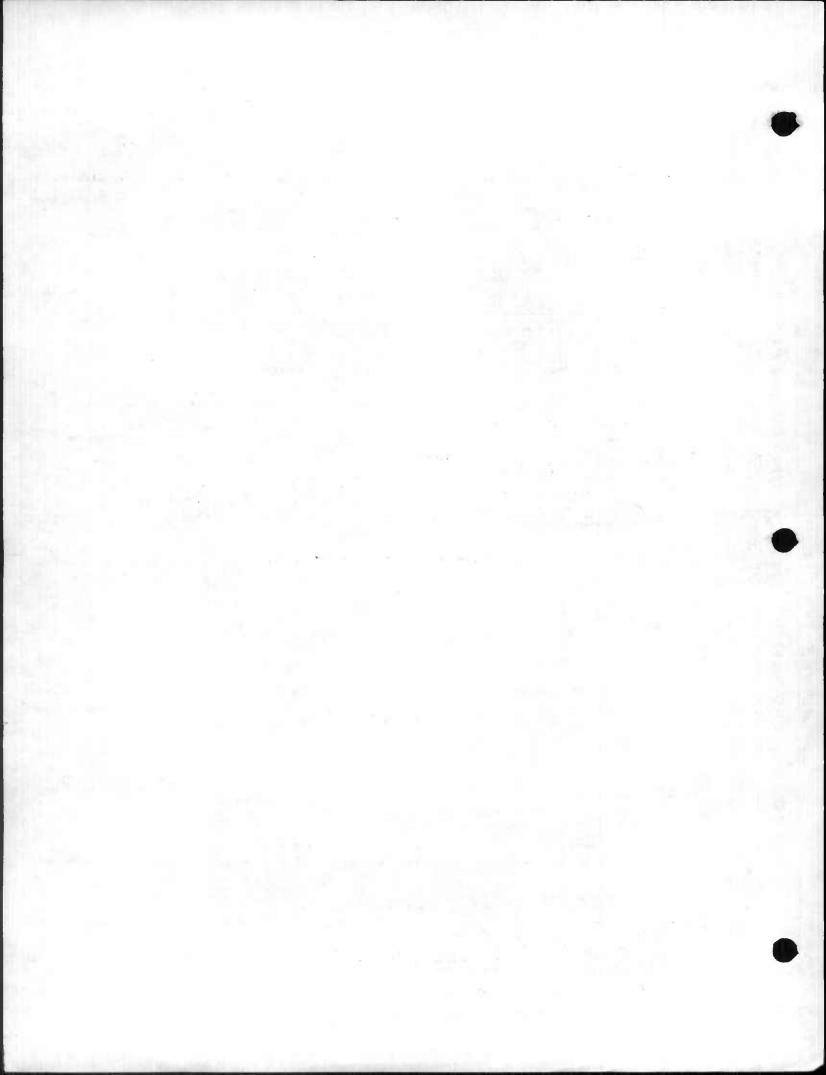
| Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth
| Months | Davs | Hours | Min. | (Month, Day, Year) 1233 HILLDALE AVE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ₩ 2DF 216 16 3678 Yrs. 74 Director MAY 24 1925 MARYLAND Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director 28a-f MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be r 1233 HILLDALE AVE 21237 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 Never Married 2 Merried 'natural', or Maryland 21215-0020 1 Yes Ž\No Specify: Specify: WHITE á 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 BOND DISTRIBUTORS SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked oth any Injury or other traumatic even HARRY H. ZIMMERMAN SR CATHERINE LOGUE 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD ZIMMERMAN / SON 1233 HILLDALE AVE BALTIMORE, MD 21237 Saltimore. 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Buriat 2 ☐ Cremetion 3 ☐ Removet from State GARDÉNS OF FAITH 10/13/99 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liganone 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical TERMINAL METASTATIC CA OF PROSTATE 5 yrs Examiner Due to (or as a consequence of): Examine ANEMIA g physician and as the burial-transit requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Due to (or es a consequence of): signed by the a 23b. Did lobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown OVERWEIGHT DUE TO DECADRON THERAPHY Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No certificate al or Attanding Physician: T a after death. Il Director: After this certificat ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred edical Certification: 28b. Time of 12 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital o within 24 hours al To the Funeral D completaly filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stelled. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1999 11 D 0010775 Oct nun ress of person who completed cause of death (Item 23a) (Type, Print) DR. H.K.A. SHIRMER 200 E. 33rd ST BALTIMORE, MD 21218

State
Registrar

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signeture



							Cei	rtificat	e of	Death		Reg. No	99 .	319	52
Physician		Natha	a (First, Middle niel	,	cton	A1tma	an				2. Date of Month Septe		y22,199		ime of Death $3:00 \mathrm{pm}$
/Medical Examiner		ty Name (/	not institution. Fulford	giva stra l Str	eet and number	er)			1	4b. City, Town,	or Location of D	aath 4c.	County of De	ath	
uneral irector	5. Social 577-	Security N 44 - 95	umber 29	6. Sex	7.	Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days		Hrs. 8. Data of Month	Birth Day Year)		irthplaca (S	Stete or Forai
how	Usual Re 10a. Star Mary		Decedent 10b. County Prince	e Geo	orges		, Town or Lo								ide City Limit
0 3 0		et and Nur						10f. Zip				10g. Citizen of What Countr			
r froms 23a direc must funeral		906 F	ulford		Was Decede Armed Force	nt Ever in U,				20735 Jent of Hispanic Origin? (Specify Yes or offy Cuban, Mexican, Puerto Rican, etc.)			ted St. 14. Race · Ar Black, WI	nerican Ind	ian,
b y			ed 2 Marri 4 □ Divorced	ed	1 Yas 2[If Yas, Give Year or Date	□No s: 19	954-	1□ Yes	No.	Specify:		,	0	Wh i te	
or than "natural", it, the Medical En Completed by	Eleme		15. Decedent ify only highes ndary (0-12)	s Educat t grade c	cion ompleted) Gollege (1-4d	1 S	56. Deced (Give life.	dent's Usua kind of wor DO NOT us	l Occup k done e retired	Occupation k done during most of working e retired)			ating	and	
eve Be	_	r's Name	First, Middle, L		J	,	Sale	Engi	neer		Name (First, Mic		r Cond:	ltion	ers
ortant: if Nem 27 is marke Injury or other traumatic	20a. Met 1 4 🗆	nod of Disp Burial 2 (Donation	☐ Cremation 5 ☐ Other (Sp	3 □Rem		CE	ace of Dispo emetery, cree ional	netory or o Memo	ne of ther plea rial	ca) Park	inton MI Date 9/24/9	20c. Le	alls Cl	nurch	, VA
Important: I any Injury o once.	1	A	en e	u	800	Lu	2:	32 Ca:	rro1		Stein H NW Washi	ngton			uneral
sician edical		ta Causa (omplicationly one							diac or respirato	ry arrest,		Onse	eximata eal Between t and Death
miner	disaasa resulting	or condition in deeth)	n	a	Metastatic Prostate Cancer 2 year Due to (or as a consequenca of):								years		
	-	,				X If any leading to immadiate								1	- F-16
transit (aminer	if any, le	ially list cor	madiate	b		Due to (or	as a consec	quenca of):							
an and nal-transit Examiner	if any, le cause. I Ceuse (I that initie	ially list cor	madiate rlying injury	b			as a conseq								
attending physician and for use as the burial-transit claryMedical Examiner	if any, le cause. I Ceuse (I that initie resulting	ially list con ading to im Enter Unde Disease or Ited events in death) t	madiate rlying injury	c d	outing to death	Due to (or	as a conseq	uanca of):	euse giv	ven in Part I.	23b.	Did tobacco	use contribu	Ite to the c	ause of deat
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State Registrar 31. Date filed (Month, Dey, Year)

30. Name and address of person who could Frederick Smith, MD

29b. Signature and title of aprili

fonth, Dey, Year)

OCT 01 1999

32. Registrar's Signeture

5401 Western Ave. NW Washington DC 20015

32. Registrar's Signeture

6. Special

29c. Licansa number

33293

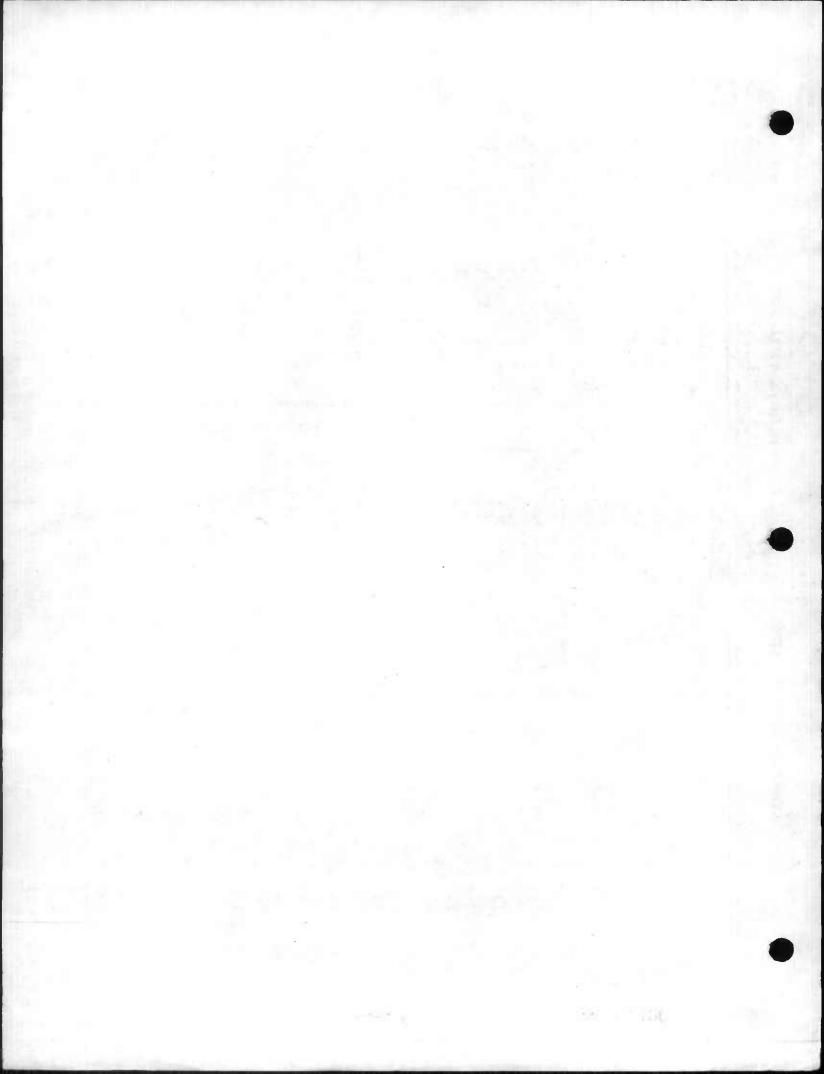
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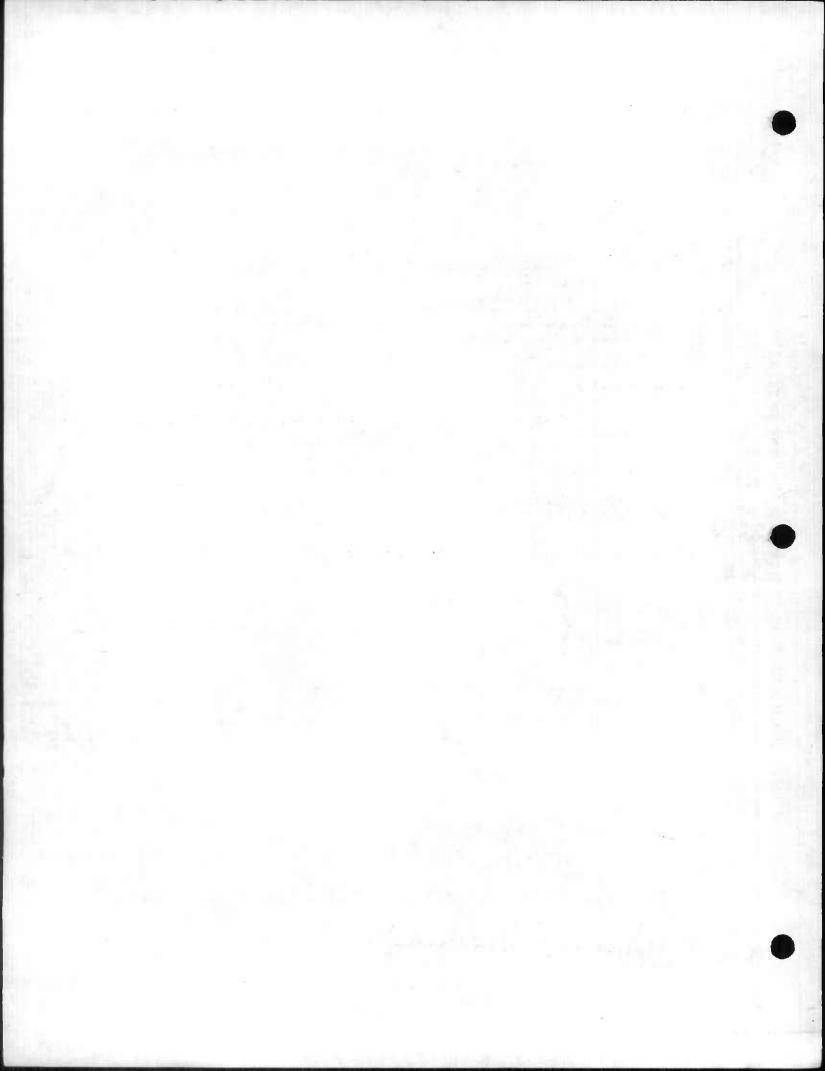
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hysician	1. Decedent's Neme (First, Mid	idle. Last)		00	incate of	Death	2. Dete of D	Reg. No.	3. Time of D			
rysician		1000					Month	Dey	Year			
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neral	100000000000000000000000000000000000000	1 M 2 F	7. Age (In yrs.	Yrs.	Months Days			ley, Year)	Birthplece (Stete or Country)			
ector	279–10–3768 Usual Residence of Decedent		86				05-17-	1913 N	West Virgin			
	10a. State 10b. Count	ty	10c, Cit	y, Town or L	ocation				10d. Inside City			
at a									1 💢 Yas			
be notfled Director	DE New C	Castle	News	ırk	Total and a				**			
Examiner must be notified at by Funeral Director	Toe. Street and Number				10f. Zip Code			10g. Citizen of W	rnat Country?			
1 0	200 East Villa				19711			United S				
drec must Funeral	11. Marital Status	Armed Fo	dent Ever in U rcas?	S. 13	Wes Decedent of It Yes, specify Cub	Hispanic Origin? (S van, Mexican, Puert	pecify Yas or N o Rican, etc.)	o- 14. Race Bleck	e - American Indien, k, White, etc.			
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100	Elementary/Secondary (0-12)		-4or 5+)	life.	DO NOT use retire	nd)						
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any injury or other traumatic event, the Medical Exami pace. To Be Completed by F	Sylvanus Prest	on Ash. Sr				Ida B. 1	Beverli	n				
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the state of the s	Pauline M. Ash	/ Wife		200	East Vill	age Road	Newarl	k. DE 10	9711			
etto	20a. Method of Disposition			lece of Disc	osition (Name of		Date	T-0-	City or Town, Stata			
8	1 Durial 2 Cremation		otate		emetory or other ple	t						
1	4 Donation 5 Other (Und		d Cemeter		10/7/1999	Ashley,	West Virgi			
any le	21. Signature of Funeral Service	Poorgsoe			eeson Men		rvices					
					053 Pulas			ark. DE	19702			
	23a. Pert1. Enter the disease, of shock, or heart feilure. Lis	or completations that cast only one cause on e	aused the deet	n. Do not e	nter the mode of dy	ng, such es cardiac	or respiretory	errest,	Approximete Intervel Between			
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ical	Immediate Cause (Finel disease or condition	An	uto Me	ne al-	1:0 Tan	Carolina			Dans			
ner	resulting in death)	a	Due to (o	r as a consi	equence of):	ruceuon			-uys			
ě		C	ar line		equence of):				Tear			
edical Examiner	Cognantially list conditions	b	Due to (o	My of G	onesce of):				Teare			
EX.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
edical	Cause (Disease or injury that initiated events	C	Due to /e									
Pa	resulting in death) Last		Due to (or	as a conse	quence or):							
/ Physician/Me		d										
100												
Physician/M	Part fl. Other significant condit	ions contributing to de	ath but not resi	ulting in the	underlying cause gi	ven in Pert I.	23b. Did	l tobacco use con	tribute to the cause of			
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6												
e e								s en eutopsy formed?	24b. Were autopsy tin evailable prior to			
-			-						completion of ca of death?			
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e Completed	25. Wes case referred to medic		tit 20	ER/Outpatie	ent 3 DOA Ot	hoe 4		sidenca 6 Othe	ar (Specify)			
o Be	25. Wes case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:						how injury occurre				
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			*	Pertificate of			g. No. 99	31964
Physician /Medical	1. Decedent's Neme (First, Middle, Maria Fatima Men	des Abreu					Day	3. Time of Death 1999 3:40 pm
Examiner	4a Facility Name (If not institution,				4b. City, Town, or Lo	ocation of Death	4c. County of	Death
Funeral Director	13505 Stock Brid 5. Social Security Number 6 577-84-9988		(In yrs. last birtho	Months Days	Silver Sp If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Montgo 1948	mery 9. Birthplace (State or Foreign Country) Portugal
pu .	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town o	or Location				10d. Inside City Limits
death with the Manjand ms 23a or 28a-f show county be notified at neral Director	Maryland Montgom		Silver					1 Yes 2 XNo
or 28a-f al	10e. Street and Number	ery	PITAGE	10f. Zip Code		10	g. Citizen of Wh	net Country?
al D	13505 Stock Brid	ge Court		20906		U	SA	
3 2 3	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	ver in U,S.	13. Wes Decedent of It Yes, specify Cub	Hispanic Origin? (Spi an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Bleck,	- Amarican Indian, White, etc. White
72 ho	15. Decedent's (Specify only highest) Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+) (()	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	pation during most of works d)	ing	6b. Kind of Bus	iness/Industry
C Herein	17. Father's Nama (First, Middle, La	st)	Hom	emaker	18. Mother's Name		wn Home)
Aental Herbard de avar	Alberto Mendes	oly .			Maria De			
2 short	19a. Informant's Name/Reletionship	(Type, Print)	19b. k	Aeiling Address (Street				tate, Zip Code)
and and and and and and and and and and	Joaquim Abreu/ H	usband	13	505 Stock	Bridge Cou			ing, MD 20906
Destrimore, Marylang Z 1 Z permit. Pages 1 and 2 should be filed within Department of Health and Montal Hyghan. Important: if item 27 is marked other then any injury or other traumatic avant, ma it page. To Be Comp	20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremetion 3 4 🗋 Donation 5 🗋 Other (Spe			ry's Cemetory	- mar-	Sept 29	Rockvil	ity or Town, State
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Glioblas	stoma Mul due to (or es a cod		,	- 6		Onset and Deeth
entificate be associted ding physician and as as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	c	ue to (or es a con ue to (or as a con					
death certific a ettending p id for use as								
d by the datache	Pert II. Other significant conditions	contributing to death but	ven in Pert I.		obacco use contribute to the cause of death (es 2K) No 3 Probably 4 Unknown			
aw requir						24a. Wes er perform		24b. Were autopsy findings available prior to completion of cause of deeth?
F 50 0						1 ☐ Ye	s 2 No	1 ☐ Yes 2 ☐ No
Physician: The this cartificate ral director, page 1: To Be Co	25. Was case referred to medical examiner?	Hospitel:		Ott	26. Place of Death			
T 를 들	1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending 2 Accident investiget	28a. Dete of Injury (Month, Day		ne of 28c. Inju	4 LI Nursing Ho	me 5 N Reside 28d. Describe ho		
tal or Attanding P as after death. as Director: After ied in by the funant Certification:	2 Accident investiget 3 Suicide 6 Could not 4 Homicide determine	ho	y - At home, ferm (Specify)	, street, fectory, office		28f. Location (Str City or Town		or Rurel Route Number,
To the Hospital or Att Within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 1 A Certifying I (Check only one)	Physician: To the best of aminer: On the basis of e and manner stets	xaminetion and/o	leath occurred et the ti or Investigation, in my o	me, date and place, opinion, daeth occurr	end due to the ca ed at the time, da	use(s) end meniite and place, an	ner es stated. Id due to the ceuse(s)
To the To the comp	29b. Signature and title of certifier	B Hens	Luh	29c. Licens D3723				(Month, Dey, Year)
10	30. Name and address of pirson wh				#205 P			
State Registrar	Carolyn B. Henar: 31. Date filed (Month, Day, Year) SEP 28 19	32. Registrer	's Signeture	Leage Dr.		inesda ,		01/



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month Day Year September 26, 1999 Patricia 8:45pm Ann Amrine 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Days Hours 1 M 2 X F Months | 66 577-44-5137 July 13,1933 Washington D.C Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Md. Rockville Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11420 Rolling House Road 20852 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Lester I. Dorr Beatrice Carroll 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stefe, Zip Code) Robert W. Amrine (Husband) 11420 Rolling House Rd. Rockville, Md. 20852 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Sept, 29, Silver Spring, Md. 4 □ Donation 5 ☑ Other (Specify) Intombment Gate of Heaven Cemetery 1999 22. Neme and Address of Facility 21. Signature of Funerel Service License DeVol Funeral Home ulles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 10 East Deer Park Dr. Gaithersburg, Md. 20877 Approximete Interval Between Onset and Deeth SEPSIS Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ARTHRITIS 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? DISEASE 2 No 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a who commented cause of death (Item 23a) (Type, Print) BETHESOA, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 16 Rev 6/95

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SEP

Bener

Physician /Medical

Examiner

Funeral Director

the Maryland must be notified at "natural", or Items 23s or

filed within 72 hours after of Hygiene. Other than "natural", or Item Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled in Department of Health and Mental Hygien important; if hem 27 is marked other the any injury or other treumatic

Physician /Medical Examiner attanding physician and for use as the buriel-transit

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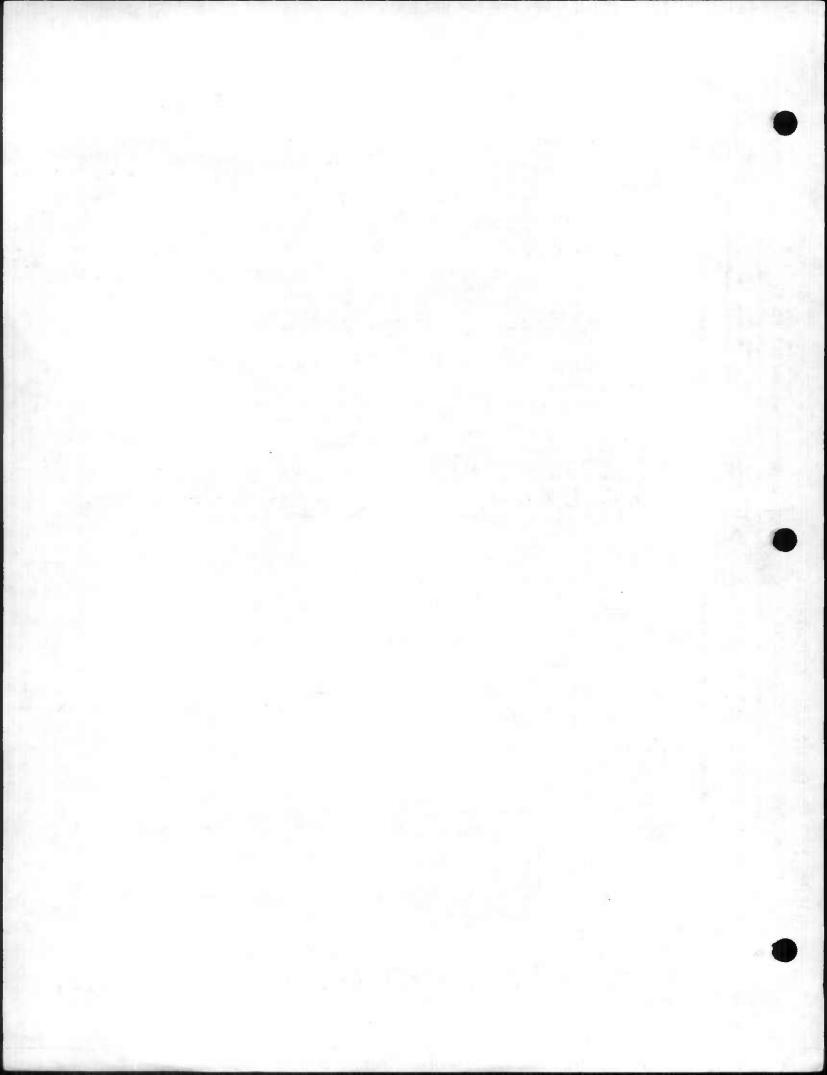
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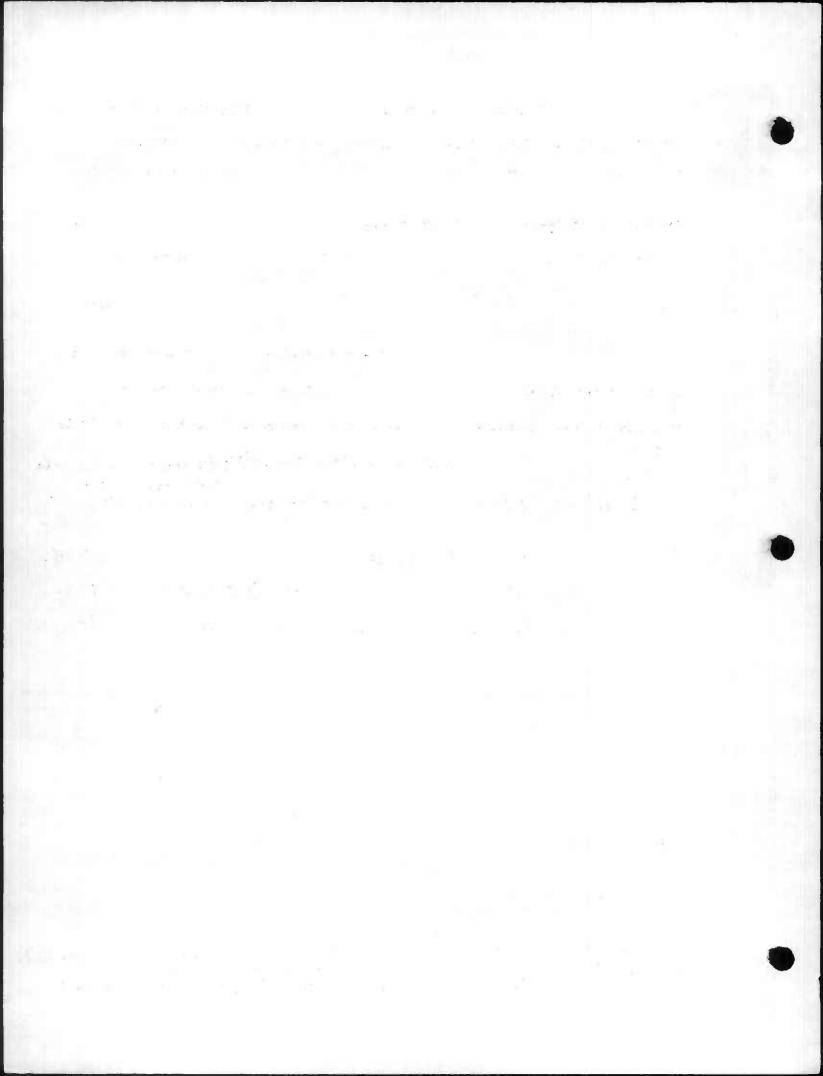
To the Hospital within 24 hours To the Funeral



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State of Maryland / Department of Health and Mental Hygiene 99 3 1 9 6 6

					Cei	tificate of	Death		Reg. No.	-'	1 200
		1. Decedent's Neme (First, Middle, La	st)					2. Dete of D		Maria	3. Time of Deeth
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7	/Medical • Examiner	4a Facility Neme (If not Institution, give			31100		4b. City, Town,	or Location of Dee			0.70 111
ä	LAGIIIIICI	WILSON HEALTH CAR	E CENTER	@ ASBURY	7 V.T	LLAGE	GAITHER	SBURG	MONTG	OMERY	7
	5	5. Social Security Number 6.5		ge (In yrs. last bi		If Under 1 Year		Irs. 8. Dete of B	irth		plece (Stete or Foreign
	Funeral Director		1□M 2QF	95	Yrs.	Months Deys	Hours M	in. (Month, D	8, 1904	Cour	ginia
		Usual Residence of Decedent	21					1105 1	, 1,01	4-1-6	5 221 2 4
	No. 18	10a. State 10b. County		10c. City, Tov	vn or Lo	cation				1	10d. Inside City Limits
	Mary Tah	Maryland Montgom	oru	Gaithe	arch	ura					1 Ves 2 No
	vith the Mar or 28a-f a be notified	10e. Streef end Number	iely	Gazene	2130	10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
	should be filed within 72 hours after death with the Marylend nd Mental Hygiene. marked other than "natural", or items 23s or 28s-f show umsite event, the Medical Examiner must be notified at To Be Completed by Funeral Director					·	7				
	urs after death w alt, or flems 23a Examiner must by Funeral	301 Russell Avenu	_	VE-res in U.C.	140.1	2087		(Cassife Van as h	United	ca - Americ	
	ar de mar	11. Merifel Stetus	12. Wes Decedent Armed Forces	?	13.	f Yes, specify Cub	en, Mexican, Pu	(Specify Yes or N erto Rican, etc.)		ck, White,	
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	alith 127 er tr	Lois Anne Sejen,	daughter				House R	d., N. B	ethesda,	MD	20852
ore	of He	20e. Method of Disposition 1 ☑ Buriar 2 ☐ Cremetion 3 ☐	- A		of Dispo	sition (Neme of netory or other ple	ece)	Dete	20c. Location	- City or To	own, Stete
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Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at each. To Be Completed by Funeral Director	21. Signature of Funeral Service Lice	napo		22	. Name end Addre	ess of Fecility				
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)	_	23e. Part 1. Enter the diverse, or com	1. / Lu	d the death. De				r., Gait		5, MD	20877 Approximete
1		shock, or heart fr lura. List only	one cause on each	line.	not ent	er the mode or dyr	ing, such es care	nec or respiratory	allest,	1	Intervel Between Onset end Death
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a	certificate rector, pag	25. Was case referred to medical									Yes 2 No
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	6	1/1/1	~	11"		0/	200	10	Septen	nber	- 23, 1999
	r	30. Neme end address of person who	completed cause of	deeth (Item 23e)	(Туре,	Print) Joel	Schul	man, m	1.7.		
		19410 DI	d Georg	ietowi	R	pad, P.	setheso	la Ma	ryland	2	0814
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	Registrar	SEP 3 0 199	39	eva	19.	Spark	2				



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month AS PM 410 4e. Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Arundel Medical Annapolis Aranda Anne If Under 24 Hrs. 8. Data of Birth
Hours Min. Month, Dey, Yea
April 14, If Under 1 Yaar 7. Aga (In yrs. last birthday) 5. Sociel Security Number 6. Sex 9. Birthplece (Stete or Foreign Months Deys 1□M 27 F Washington, DC 213-42-5277 94 Yrs 1905 Usuel Residanca of Dacedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Queen Anne Stevensville 10f. Zip Code 10g. Citizen of Whet Country? 21666 USA 12. Wes Decedant Evar In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 Yas 2 TNo If Yes, Giva Yaar or Dates: 1 Yes 2XXNo Specify: White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Own Home

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Experiments.

Physician

/Medical

Examiner

10e. Stete

Funeral

Director

Physician /Medical Examiner

and physiclan tha signed by the attending p has page 2 cartificata To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifica funaral director,

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Director MD 10e. Street end Number 310 Kentmoore Road Funeral 1 Nevar Marriad 2 Merried ð 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) Elementery/Secondery (0-12) Homemaker 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Surneme) Carrie Kline Clarence Ladow 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 310 Kentmoore Road Stevensville, MD Charles William Atwell 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stete Sept. 1999 XXXBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Union Cemetery Leesburg, VA 21. Signeture of Funaral Sarvice Licenses 22. Nama and Address of Facility
Colonial Funeral Home 201 Ed Ferry Rd NE Leesburg, Virginia int. Enter the diseesa, or complications thet caused tha death. Do not entar tha moda of dying, such es cardiac or raspiratory arrest, lock, or haart feliure. List only one cause on each line. Immediete Ceuse (Finei disaasa or condition resulting in deeth) ue to (or es a consequence of) Examiner Rumonia Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Completed by 24e. Wes an autopsy performed? 1 Yes 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Chack only one) 1 Yes 20 No Hospital: Certification: To Inpatient 2 ER/Outpatient 3 DOA 28h. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No filled In by tha 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, determined to the cause(s) and manner as stated. 29e. Certifier Medical complataly Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) 29b. Signature and title of certified 29c. License number en of deeth (Item 23e) (Type, Print) Start Annapolis Franklin Jens 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture SEP 28

Approximata Interval Between Onset end Deeth

23b. Did tobacco use contribute to the cause of death?

1 Tyes 2 No 3 Probably Unknown

24b. Were autopsy findings available prior to completion of cause of deeth?

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

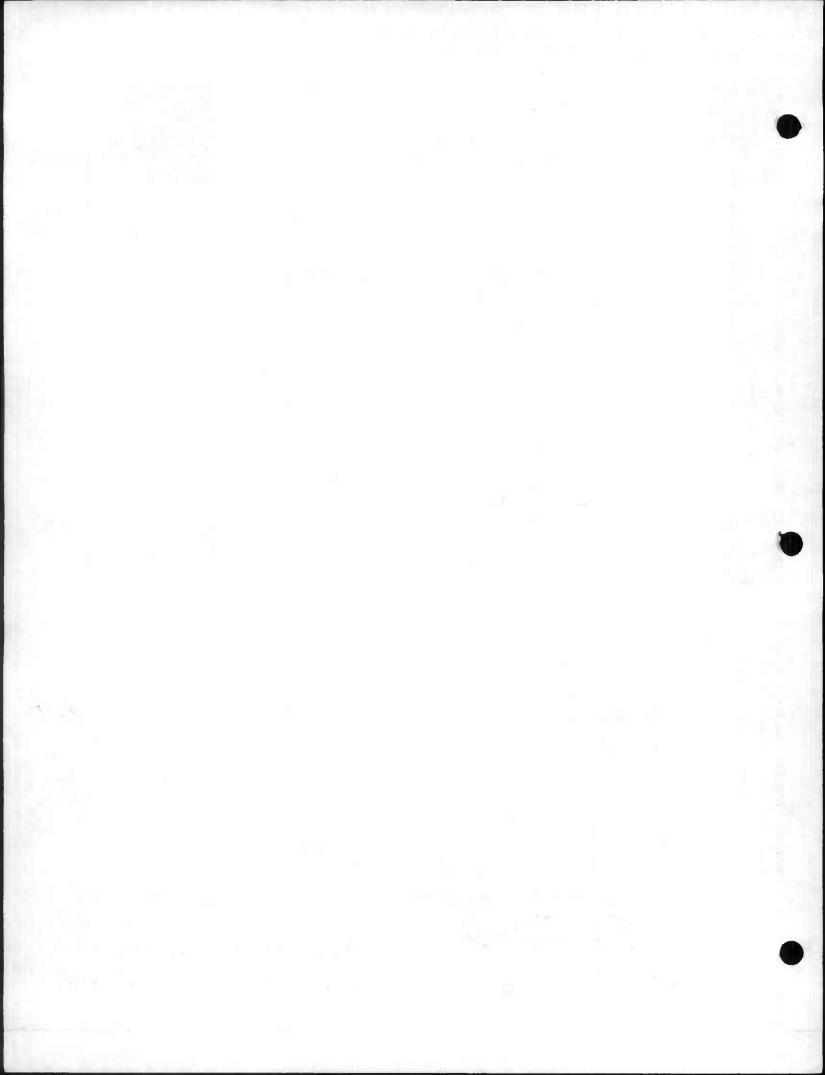
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

21401

State Registrar

1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First, Middle, La	est)		tificate of		2. Deta of Deat			. Tima of Death
ysician Jedical	JACK CARLYOW	AUSHERMA	yN			SOMEWED	Day	Year [QQQ	1710
aminer	4e Facility Neme (If not institution, give 17138 THORNTON)				4b. City, Town, or L	ocation of Deeth	4c. County		4
eral ctor	5. Social Security Number 6. S 218 30 7901 Usuel Residence of Decedent	Sex 7. Age (In y 62	rs. lest birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey, SEPT.30	,1936	9. Birthplace Country) MARYLA	(Stete or Foreig
or sdat	10a. State 10b. County MD . MONTGOM		City, Town or Lo	cation					Inside City Limit
rect	10e. Street and Number		OLIVE!	10f. Zip Code		1	0g. Citizen of V		
aj Di	17138 THORNTONDAI	LE COURT		20	0832		UNITED	STATE	S
Examiner must be notified at	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 19 1 Styles 2 No If Yes, Give 195		Was Decedent of H 1 Yas, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Span, Maxicen, Puerto Specify:	pecify Yas or No- p Rican, etc.)		e - American li ck, Whita, etc.	
Completed	15. Decedent's E (Specify only highest on Elementary/Secondary (0-12)	ducation ede completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work dona DO NOT use retire	during most of world)	king	16b. Kind of Bu		ry
Be Co	17. Fathar'a Name (First, Middle, Last		OWNE	N - OILIN	1	ne (First, Middle, I			
ToB	CLYDE W. AUSHE	RMAN			RUTH	MULLIC	AN		
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once. To Be Completed	CAROL M. AUSHERM. 20e. Method of Disposition		. Place of Dispo	sition (Neme of	ONDALE CO		20c. Location -		
	1 ☐ Buriai 2 ☐ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, cren	netory or other ple TAN CREMA			ALEXAND		
once.	21. Signature of Funarai Service Licer		/ 22 M	Name and Addra	BARBER F	UNERAL H	OME		
dical Examiner	disaase or condition resulting in death) Sequentially list conditions, if any leading to immediate	b	o (or es a conseq	uence of):	ome of				
edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseasa or Injury that initieted events resulting in death) Last	c. Dua to	o (or as a consaq	uance of):				1	
Physician/M	Pert II. Other significant conditions of	contributing to death but not	resulting In the u	nderlying ceuse gi	ven in Part I.	23b. Did to	bacco uae co	ntribute to the	cause of death
by						1 🗆 Y	es 2 No	3 Probabl	ly 4 Unknow
Completed	37					24a. Wes a perfor	in autopsy med?	availat	eutopsy findings ble prior to etion of cause th?
	25. Was cese referred to medical					1 🗆 Yı		1 🗆 Ye	es 2 0 40
To Be	examiner?	Hospital:	□ ER/Outpatien	t 3 DOA Ott	her: 4 Nursing H	oma Reside	ence 6 □Oth	er (Specity)	
	27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year	28b. Time of	28c. Inju Wo		28d. Describe he			
8	3 Sulcide 6 Could not be determined	28e. Place of Injury - A building, atc. (Spe		eet, fectory, office		28f. Location (Si City or Town		per or Rurel Ro	oute Number,
Certification:									
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

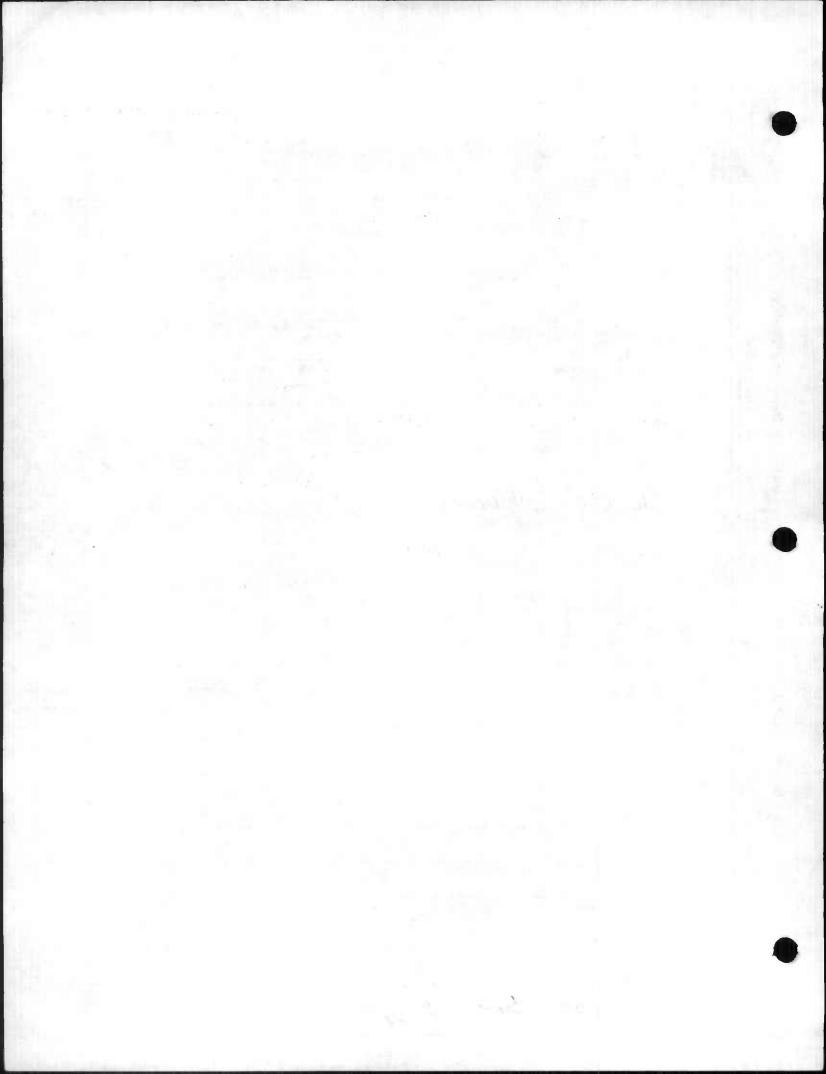
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	Certificate	of	Death	

וון דוף ווין דוף ו	red all a	- Indiana	Certificate of	Death	Reg. No.	31969
Physician /Medical	Decedent's Name (First, Middle, Last DONNA RAE BROK	Brooke		Mor	of Death oth Day	3. Time of Death Year 1999 7:10 pm
Examiner	4a Facility Nama (If not Institution, giva SACRED HEART HOS			tb. City, Town, or Location of CUMBERLAND	Death 4c. County	of Death
Funeral Director	210-34-4390	7. Age (In yrs. Ia.	st birthday) If Under 1 Year Months Days	Hours Min. 8. Date (Mor MAR •	of Birth oth, Day, Year) 9,1938	Birthplace (State or Foreign Country) MARYLAND
the Meryland 28=1 show notified at	Usual Rasidence of Decedent 10a. Stata 10b. County MD ALLEGAN		Town or Location	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		10d. Inside City Limits 1 ☐ Yes 2月 No
uter deeth with the Meinter deeth with the Meinter of theme 23e or 28e-1 sincer must be notified from Funeral Director	10e. Street and Number 11626 APOLLO AVE	NUE, S.W.	10f. Zip Code 2150:	2	10g. Citizen of U.S.	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs	ispanic Origin? (Specify Yea an, Mexican, Puerto Rican, e Specify:	s or No- lic.) 14. Red Bla Specif	ce - American Indian, ck, Whita, etc. WHITE
nd 21215-0020 a filed within 72 hours af al Hygiens, or other than "natural", or vent, the Medical Exam Se Completed by I	15. Decedent's Edu (Specify only highest grad Elemanlary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired STITER	during most of working	HEALTH	usiness/Industry CARE AND DAY CARE
yland be file Mentel Hymerked other artic event.	17. Fathar's Nama (First, Middle, Last) ALBERT SHAFFER			18. Mother's Name (First, I GRACE SMITH		na)
e, Mar 1 and 2 sho Heelth end Pm 27 is my ther traum	19a. Informant's Name/Ratationship (T) ROBERT C. BROOKE 20a. Mathod of Disposition	/ SON	19b. Mailing Address (Street 11626 APOLILO 2 ce of Disposition (Name of		UMBERLAND,	
Paga nent o ant: If any or	1 DBurial 2 Cramation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funaral Service License	Removal from Stata RESII	AWN MEMORIAL CARI	ENS 9/30/9		LAND, MD
Physician /Medical Examiner	23a. Par1. Entar tha disease, or complishock, or haart failura. List only of Immediata Causa (Final diseasa or condition resulting in death)	encephalo	202 CREENE S		atory arrest,	Approximata Interval Between Onset and Death
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P.O. do by the detached	Part II. Other algoriticant conditions con	ntributing to death but not result $QH + QUU$	ing in the underlying cause giv	ren in Part I. 23	b. Did tobacco use co	ontribute to the cause of death?
ecord ew requir ss been s 2 should				244	a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital I Physician: The ribis certificate and director, page 1: To Be Co	25. Was casa referred to medical examinar?	Hospital: 1 Inpatient 2 □ El	R/Outpatient 3 DOA Oth	26. Place of Death (Check	k only one)	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
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To the comp	29b. Signature and title of certifier	nger. Mio.	29c. Licens	e number 9 231		od (Month, Day, Year)

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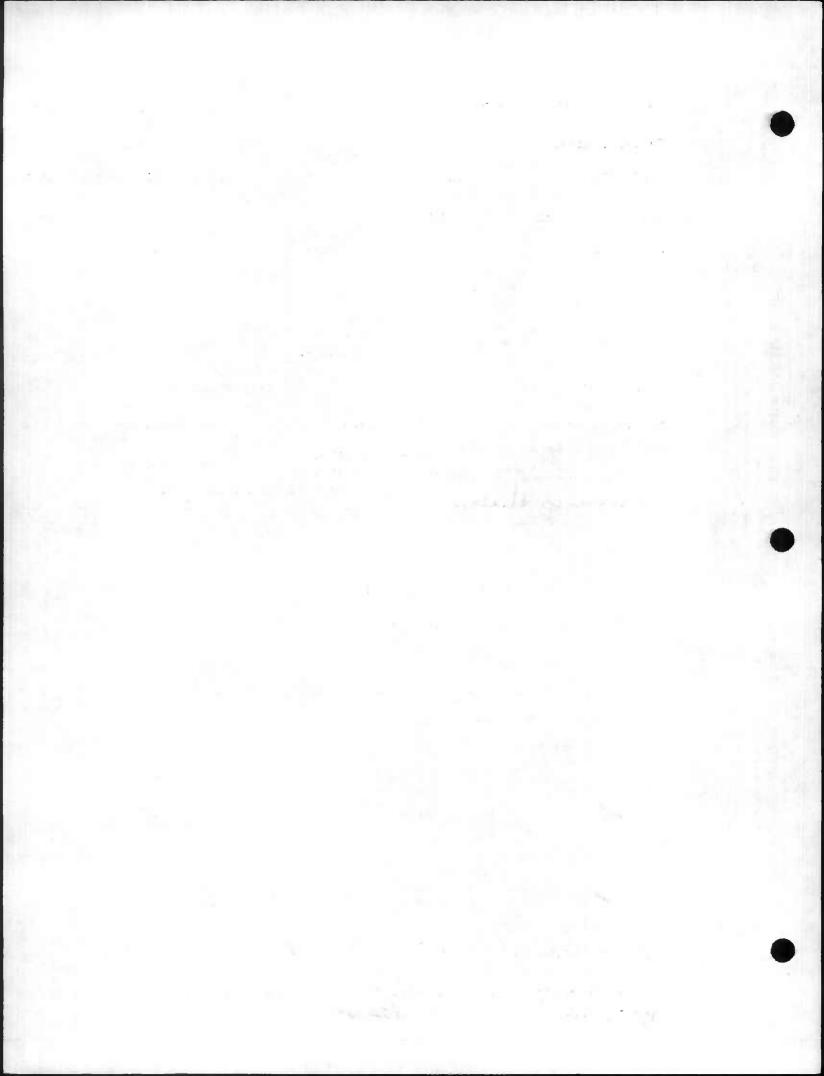
31. Date filed (Month, Day, Year)
OCT 0 4 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)
DINALI) MANGEL 1442 HAZE 14427 HAZEN ROAD N.E. CHMBERLAND MO21502



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical Examiner	4a Facility Nema (II	not institution, giv	a street and num	ber)			4	b. City, Town, o	r Location of De		nty of Deeth	2011
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29 1999 1813

3. Time of Deeth

Birthplece (State or Foreign Country)

White

21635

29d. Date signed (Month, Day, Yeer)

Approximete Intervel Between Onset end Deeth

10d. Inside City Limits

1 ☐ Yes 2 No

If item 27 or other t permit. Pege Department of Important: If any injury or **Physician** /Medical **Examiner** the buriel-transit be executed Box 68760. Tha law requires that the death certificate datached for use P.0. ate has been signed paga 2 should be da Records, certificate has of Vital Attending Physician: 2 in by the funeral Certification: After Division death. i or Attend after death Director: 24 hours Hospitai Medical within 2 To the To the

Month JOHN THOMAS BRYANT SR September 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Kent & Queen Anne's Hospital Chestertown Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. lest birthday) **Funeral** M 20 F Days Yrs **Director** 70 222-18-0766 May 6 1929 Pennsylvania Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location rai", or items 23s or 28s-f show Examiner mant be notified at Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8794 Fairlee Rd. 21620 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Merrled 1X Yes 2 □ No 21215-0020 "natural", or If Yes, Give Year or Detes: 1 ☐ Yes 2X No þ 3 ☐ Widowed 4 ☐ Divorced Completed The Medical 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ith and Mantei Hygiene. 27 is marked other than "r r traumatic event, in a Med Elementary/Secondery (0-12) College (1-4or 5+) 12 Truck driver Trucking Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be form of Health end Mantei Int: If Item 27 is marked of Albert Raymond Bryant Sr. Catherine Opdenecker 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8794 Fairlee Rd. Chestertown, MD. 21620 Marjorie Bryant (wife) 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State 10/3/99 Galena, Galena Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral-Bervice Ligardice 22. Name and Address of Fecility
Galena Funeral Home of Stephen Schaech Galena, MD. M00510 118 West Cross St. the ese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, feilure. List only one cause on each line. CACDIAC ARRUST Immediete Cause (Finel diseese or condition resulting in death) Due to (or es e consequence of) Examiner - OROSUMOD INFANCT MYDCARDIAL EDEMA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) CONSUMPTIVE COAGUIDPATHY Physician/Medical 2000 OXIGNADING Pert il. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

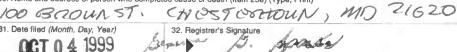
ADDITO-BITLING ANDUNYSM. 23b. Did tobacco use contribute to the cause of death? UNGONT LASCULAR SURGODY FOR ABOUT DA 1 Yes 2 No 3 Probably 4 Onknown Be Completed by 24e. Wes an autopsy performed? REMOTE MYOCARDIAL INFANCT 24b. Were eutopsy findings aveileble prior to EMPHYSOMX, completion of cause of deeth? (PASION HAD CARDIAL PRE-OP. CLOTICINO 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? He Occurred Hospitel: 112 Inpatient 2 ER/Outpetient 3 DOA 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the cause(s) end manner as steted. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

+IVA

State Registrar

31. Dete filed (Month, Day, Year) OCT 0 4 1999

29b. Signeture end title of certifier



30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

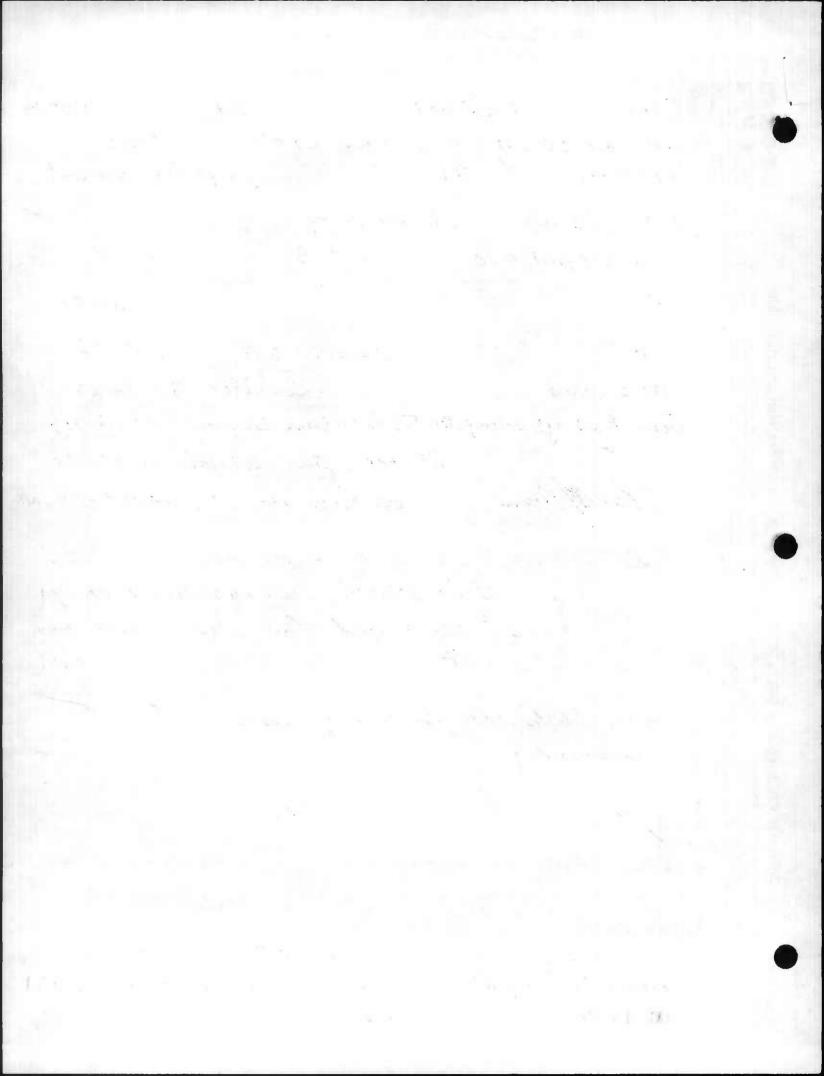
29c. License number

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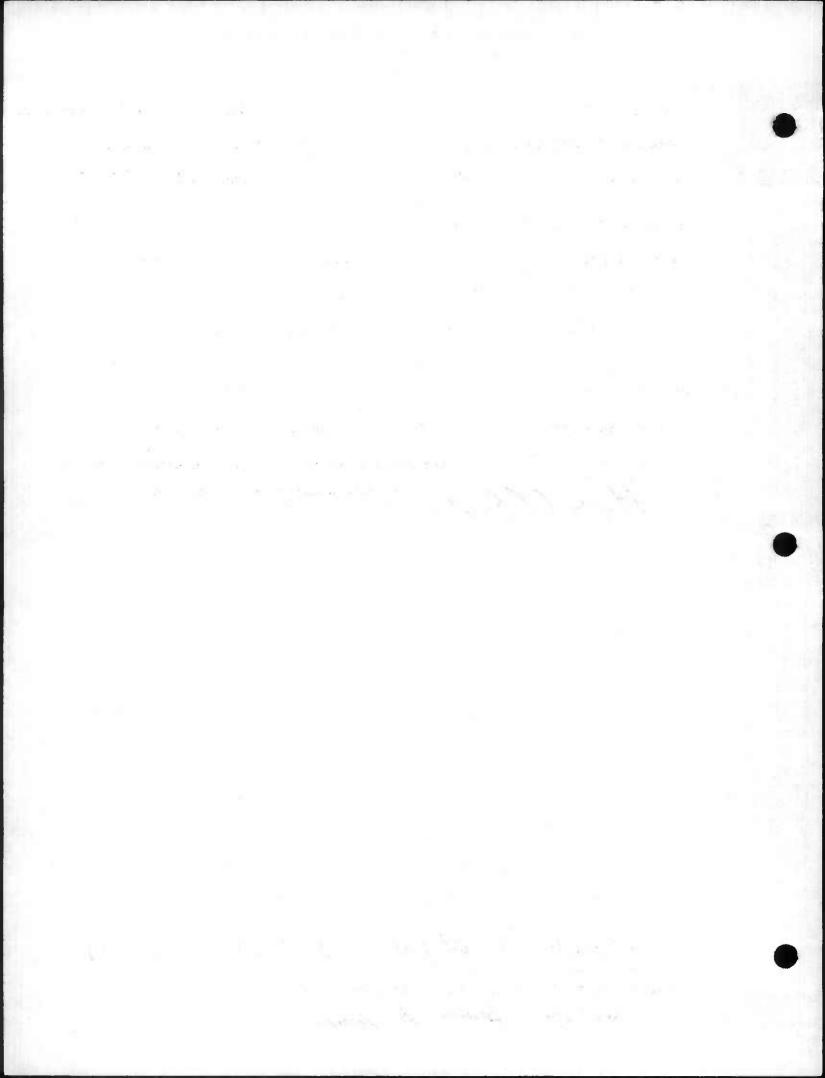
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND #5 Cecil County Health Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:00 Am , 1999 Sept 30 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number, 4c. County of Death Examiner ELKTON

If Undar 24 Hrs. 8. Date of Birth
(Month, Day, Yaar) CASE 100 LAWIELDINE Cecil AUTELWOOD 7. Age (In yrs. last birthday) **Funeral** 1□ M 2♥ F Days Director MAY9,1915 Vermont Usual Rasidence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at CECIL 1 Yes 2 No ChesAPen KeciT Directo 10e. Street and Number 10g. Citizen of What Country? GraySON 310 2191 u.S. AUC Funeral death 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 end 2 should be filled within 72 hours after. Department of Heelth and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No ff Yes, Giva Year or Dates: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No λq WHITE 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HOSPITAL Elementary/Secondary (0-12) College (1-4or 5+) House Keeping DePt 17. Father's Nama (First, Middla, Last) 18 Mother's Neme (First, Middle, Meiden Sumema) Tennifer BAird HOCL Lo 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) PARKLANE 59 Pennington-Daughter MD. 21919 EARLEVILLE 20b. Place of Disposition (Nama of cematary, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State ò RA any Injury c 4 ☐ Donation 5 ☐ Other (Specify) Ferris INC tice hureral Home 259 E. MAIN St. 23a. Part1. Entar the description of complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart to up. List only one ceuse on each line. Physician Immediate Cause (Final disease or condition resulting In death) /Medical 10 mi **Examiner** Due to (or as a consequen Examiner certificate be axecuted burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieled events resulting in death) Last and Due flor as a consequence of): ettending physician for use es the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 98 Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? Completed certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Yaer) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 2 No 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ò A 24 hou. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. To the Within 2 29d. Data signed (Month, Day, Yaar) 29b. Signatura and titla of certifiar would led cause of death (Item 23a) (Type, Print) 30. Name end address of peguan wt. St. Suite 310 El Kton MD 21921 W. High 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 0 4 1999 Registrar

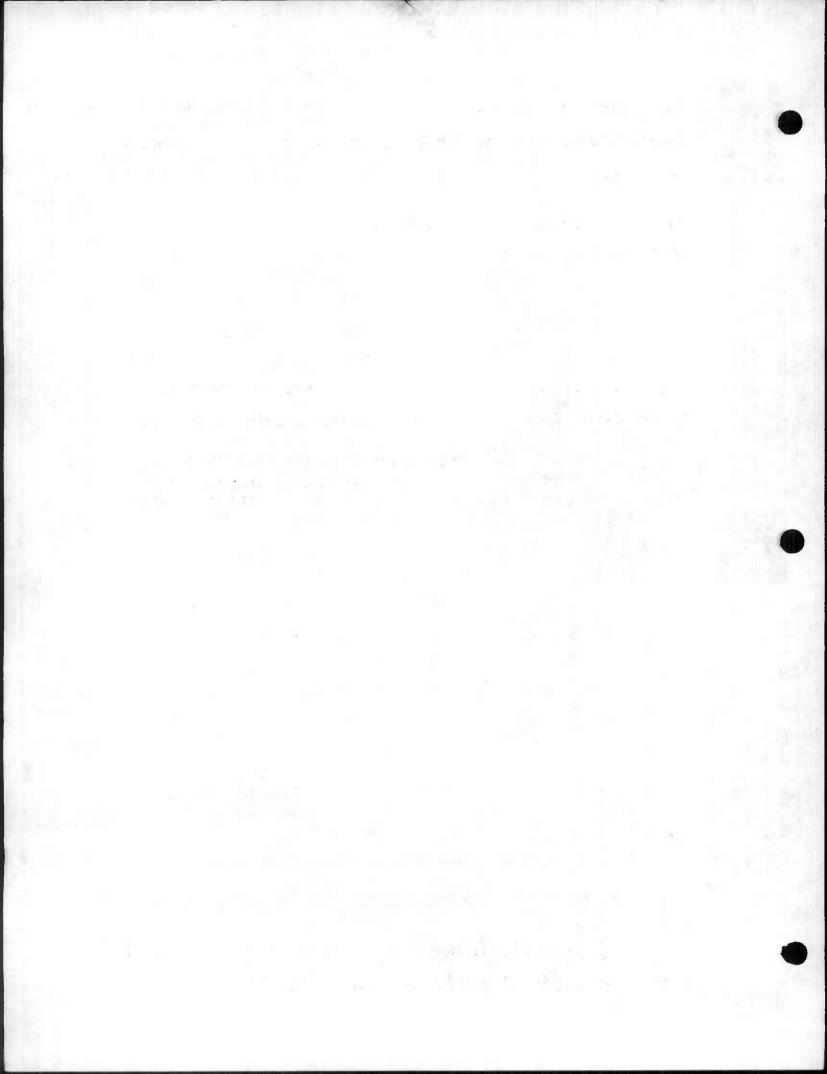


State of Maryland / Department of Health and Mental Hygiene

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	/Media		Mary H Buckle						SEPT.	27 19		10:40A.M
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			CAROLINE NURSING	HOME, INC.				ENTON, MA		CARO	LINE	
	Funeral Director		5. Social Sacurity Number 6. Se 1221–12–8250	M 20 F	(In yrs. last bir 30	Yrs. If Uni	dar 1 Yaar ns Deys	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day Aug 11,	Year) 1919	9. Birthpiaca Country) Mary La	(Stata or Foraign nd
	yland		Usual Rasidence of Dacedent 10a. Stata 10b. County		10c. City, Tow	n or Location					10d. I	Inside City Limits
	Mar	to	Maryland Caroline		Denton							1 No Yas 2 No
	r 28	Director	10e. Street and Number		DOMESTI	10f.	Zip Coda		1	0g. Citizen of W	hat Country?	
	38 c		520 Kerr Ave				21629)		USA		
	deat	Funeral	11. Marital Stetus	12. Wes Decedent E	ver in U,S.	13. Was Da		Ispanic Origin? (S an, Maxican, Puart	pecify Yas or No-	14. Rece	- American in	ndian,
020	s within 72 hours after death with the Maryland liene. Then "naturel", or items 23s or 28s-f show the Modical Examiner must be notified at	by	1 Naver Merried 2 Married 3 XWidowed 4 Divorced	Armed Forcas? 1 ☐ Yes 2 XN If Yes, Give Yaar or Dates:	0		_	Specify:	o Rican, atc.)	Specify:	whita, atc. Whit	:e
ŏ	2 hou	8	15. Decedent's Edu	cation	16a.	Decedent's U	sual Occup	ation		16b. Kind of Bus	sinass/Industr	γ
Maryland 21215-0020	filed within 72 Hygiene. Ather than "nat	Completed	(Specify only highast grad	a completed) Collega (1-4or 5-	+)	(Giva kind of lifa. DO NOT	work dona Tuse retired	durina most of wor	king			
0	be filed stal Hygi d other event, t	ŏ	17. Fathar's Nama (First, Middle, Last)		п	omemake	er	18. Mothar's Nan	na (First, Middle,	OWn he	of the same	
au	a a b ≥	Be c	Alpheus Horney								~)	
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a,	1 an Heal		Kathryn Stranahan 20a. Mathod ol Disposition			BOX 28		dgely, M		21660 20c. Location - 0	City or Town	Stata
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	tant tant		4 □ Donation 5 □ Other (Spacify)		Greens	sboro C			-30-99 G	reensbo	ro, Ma	ryland
Baltimore,	permit. Pages Department of I Important: If ite any injury or or once.		21. Signatura of Funaçal Sarvice Licens	FL	1	Fleeg		ss of Facility Helfenbe	in Funer sboro, M		216	20
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1	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition rasulting in death)	Pro	Dua to (or as a						On	set and Death
68/60,	ficate be axecuted g physician and as the burial-transit	edical Examiner	Sequantially list conditions, if any, leading to immadieta cause. Enter Underlying Cause (Disaase or injury that initiated evants resulting in death) Last	o. —————	Oua to (or as a coue to (or as a co	consequence o						
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>	yalci s ce direc	To	exeminar?	lospital:	t 2 ER/Ou	tpatient 3	DOA Oth	er: 4 Nursing H	loma 5 Rasid	ance 8 DOtha	r (Specify)	
0	Ph er thi		27. Manner of Deeth	28a. Data ol Injun	28b. 1	Tima of	28c. Injur Wor			ow injury occurre		
0	offin Hh.: After e fun	atlo	1 ☑Netural 5 ☐ Panding 2 ☐ Accidant invastigation	(Month, Day	Year)	njury M		Yas 2 □ No				
Division of	N or Atte	Certification:	3 Suicide 6 Could not be determined	28a. Place of Injubuilding, etc.	ry - At homa, fe (Specify)	rm, straat, fact	tory, offica		28f. Location (S City or Tow		er or Rural Ro	ute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Cartifiar (Check only one) 1 Certifying Physical Examination (Check only one)	sicien: To the best of ner: On the basis of and mennar stat	axamination an	, deeth occurred/or invastigati	ed et the tin ion, in my o	ne, dete end plece plnion, death occu	, and dua to the c rrad at tha tima, d	eusa(s) and mar lata and piace, a	nnar as stated nd dua to the	l. cause(s)
	Vithir To th	Me	29b. Signature and Hila of cartifiar	0	1.	J., 13	29c. Licans	a number	2	9d. Data signed	(Month, Dey,	Year)
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			30. Nama end eddrass of person who co	emplated causa of de	ath (Itam ^V 23a) (Typa, Print)						
			Karen Moffett MD	Daffin I		nton, M	lary1a	nd 2162	9			
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_				ate of Maryland	Certifica				Reg. No.	3197	L
	Physic /Medi			Barber				2. Dete of De Month Sept.	30 199	3. Time of 0	Deeth Opm
	Examil Funeral Director		4a. Fecility Neme (If not institution, give straat Charles County Nu 5. Sociel Sacurity Number 214-74-7607 6. Sex	rsing Reha		er der 1 Yaar	La Pla If Undar 24 Hrs. Hours Min. Oc	8. Date of Bir	Char		Foreign
	nyland show dat		Usuel Residance of Decedent 10e. State 10b. County	10c. City, T	own or Location					10d. Inside City	y Limits
	death with the Marylan TRE 23e or 28e-f show . Ithust be notified at	Director	MD Charles 10e. Street end Number	La	Plata	Zip Code			10g. Citizen of W	1 X Yes	2 🖺 No
0		Funerai	10200 La Plata Ro 11. Marital Status 12. W. Ar 1□ Never Married 2□ Married 1.0	es Decedent Evar in U,S. med Forces? □ Yes 2 □ No			spenic Origin? (Sp n, Mexican, Puerto	pecify Yas or No Rican, etc.)	USA 14. Race Bleck	- American Indien, , Whita, atc.	
Maryland 21215-0020	hin 72 hours after in "natural", or lit Medical Examin	Completed by	3℃ Widowed 4 □ Divorced Ye 15. Decedent's Education (Specify only highast grade com,	Yes, Give per or Dates: pleted) bliege (1-4or 5+)		suel Occupi work done of use retired	Specify: ation funing most of work	king	Specify:	White Iness/Industry	
nd 21	be filed within vial Hygiens. d other than *event, the Me	Ве Сош	12 17. Fether's Neme (First, Middle, Last)	niege (1-401 5+)	Homema	ker	18. Mother's Nem	ne (First, Middla,	Ho Meiden Sumema		
laryla	2 should be and Mental is marked of surratic ev	To	Edgar M. Hickman 19e. Informent's Name/Reletionship (Type, Pr					rel Route Numbe	er, City or Town, S		
	Pages 1 and 1 nart of Health ret: If leen 27 i		Gilbert Barber/Son 20e. Method of Disposition 1 Burlal 2 Cramation 3 Remove	20b. Place	e of Disposition (f	Verne of or other plec	a)	Date	20c. Location - C	A 23235 City or Town, Steta	
Baltimore,	permit. Pa Departmen Important: any Injury 2058.		4 Donation 5 Other (Specify) 21. Signature of Funerel Service Licensee	Holy	ÂREH.	and Address ART-I	CHOLS	FUNERA	L HOME	Maryland P.A.	
	Physician		23a. Pert1. Entar the disease, or complication shock, or heart feilure. List only one ceu	s thet caused tha deeth. It se on each line.	P.O.	BOX	56/ LA	PLATA	,MD 206	Approximete Intervel Betwo	าดอก
	/Medicai Examiner		Immediate Ceuse (Final disease or condition resulting in death)	Pue to (or es	a consequenca o	of):					
30,	ficate be executed physician and is the burial-transit	i Examiner	Sequentielly list conditions, if any, leeding to Immediate causa. Enter Underlying Cause (Disease or injury	Due to (or es	e consequence o	of):					
Box 68760,	E 0 €	in/Medical	that initiated events resulting In deeth) Last	Dua to (or as	a consequence o	of):					
o.	the d	Physician/M	Pert II. Other significent conditions contribution	ng to death but not resulting	g in tha underlyin	g cause give	nn in Part I.	23b. Did 1	_/	ribute to the cause of	
ords, P	requires ween sign hould be	by	Carolia, au	lighter				24e. Wes	en eutopsy	24b. Were eutopsy fin evaileble prior to completion of car	ndings
Vital Record	The lay ate has page 2	Completed						101	res 2 DHNo	of deeth?	,
	iing Physician: The n. After this certificate funeral director, pag	ion: To Be	1 Neturel 5 ☐ Pending	1 □ Inpatient 2 □ ER/	Outpetient 3	28c. Injury Work	at ?	ome 5 Resid	ne) denca 6 □Other now injury occurre		
Division of	To the Mospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicida 6 Could not be determined 28a	. Placa of Injury - At home, building, etc. (Specify)	M , ferm, straet, fact		/es 2□No	28f. Location (S City or Tox		or Rural Route Number	er,
	To the Hospital or within 24 hours after to the Funeral Director Completely filled in	edicai	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: Or en	To the best of my knowled the basis of axeminetion dimenner steted.	ige, deeth occurre end/or investigation	ed at the tim on, in my op	e, dete end placa, inion, deeth occur	end due to the ored at the time,	cause(s) end men dete end place, en	ner es steted. Id due to the causa(s)	
	Vithi To the	Charles .	29b. Signature and titla of certifiar	Bul us	2	29c. License	0100	9	29d. Data signed	(Month, Day, Year)	
			30. Name and address of person who complete P.O. Box 2539	ed cause of deeth (Item 236	e) (Type, Print)	nD.	2064	6			
	Sta Registr	ı.e	31. Dete filed (Month, Day, Year) 1 1999	32. Registrar's Signature		Spar	K				



Piease Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month **Physician** Kathryn Campbell Babcock September 27, 1999 0820 /Medical 4a Facility Neme (II not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 X F Director 577-30-6626 84 1914 31, Pennsylvania Usual Residence of Deceden the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo 28a-f Maryland Montgomery Bethesda 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 238 United States

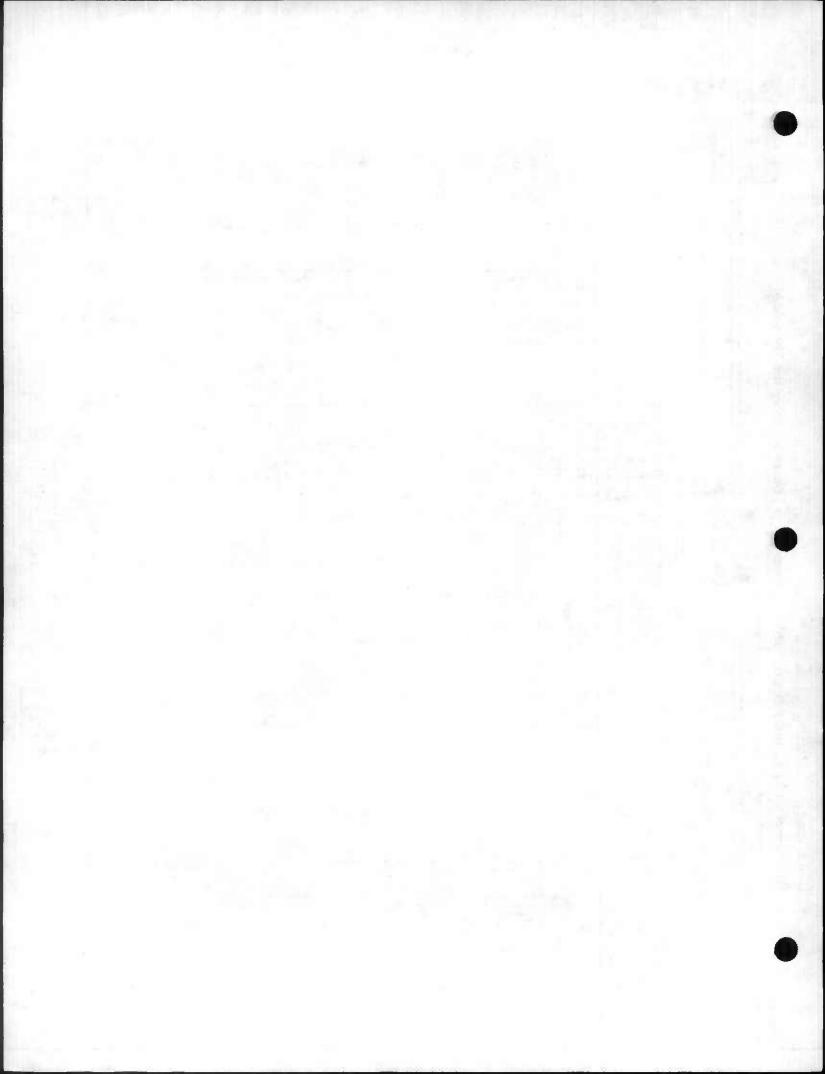
14. Race - American Indian,
Black, White, etc. 20817 Funeral 7059 Wilson Lane Berna 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status r than "natural", or itse the Medical Examiner 72 hours after 1 Never Merried 2 Married 21215-0020 1 Yes 2 No Specify: Yes. Give by 3 Widowed 4 Divorced Yeer or Detes White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. other then "n Elamentery/Secondary (0-12) College (1-4or 5+) Librarian Library of Congress permit. Pages 1 and 2 should be file Department of Health and Mental Hyg important: If Nem 27 is marked other any Injury or other traument other 9068. Baltimore, Maryland 17. Father's Nama (First, Middla, Last) 18 Mother's Nama (First Middle, Maiden Surnama) Be Madelaine Jackson F. Ray Campbell 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Ralationship (Type, Print) Wallace I. Babcock/Husband 7059 Wilson Lane, Bethesda, Maryland 20817 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 20b. Plece of Disposition (Nama of cemetary, crematory or other place) Sept 29 20c. Location - City or Town, Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signeture of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ لي Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 20 23a. Part1. Enter the disease, or complications that claused tha death. Do not entar the mode of dying, such as cardiac or raspiretory errest, shock, or heart failure. List only one ceuse on each line. M00803 Bethesda, Maryland 20814-3501 Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in daath) /Medical Anoxic Encephalopathy 48 Hours Examiner Due to (or as a consequence of) Examiner Cardiac Arrhythmia 48 Hours Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760 Emphysema Years Physician/Medical Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown PV 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No 25. Wes case referred to medical axaminar? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospitei: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 1 Npatient 2 ER/Outpatient 3 DOA Division of 28a. Dete of tnjury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending 1 TYes 2 No Investigation 2 Accident Director 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) after 4 Homicide 6 hours Funeral 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. To the Hos within 24 h To the Fur (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certifian albert MD D46052 September 27, 1999 30. Name and address of person who complated causa of deeth (Item 23a) (Type, Print) Sjoerd Beck, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

DHMH 16 Ray 6/95

Registrar

SEP 29 1999

ORIGINAL

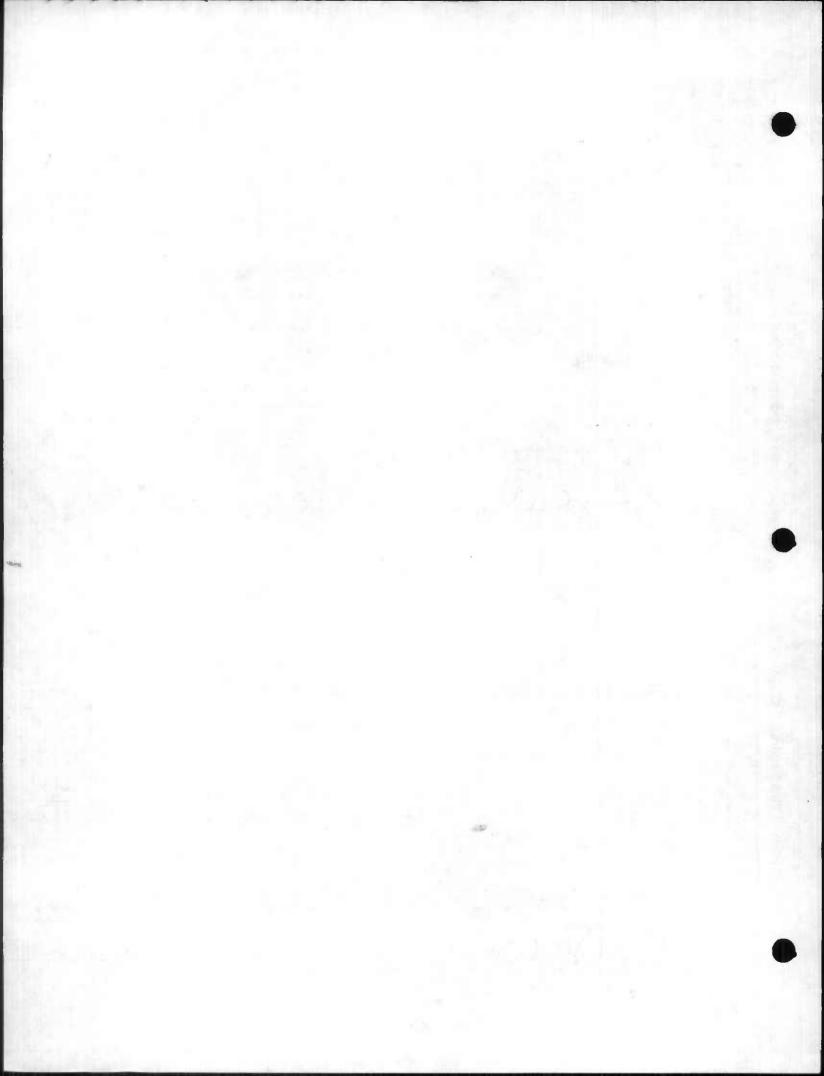


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month September 27, 1999 8:50 P.M. **Physician** Aristotle Bacas /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3206 Winnett Road Chevy Chase Montgomery If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) March 20, 1929 Washington, DC 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Days Months 1 MM 2□ F 577-38-2167 70 Director Usual Residence of Decedent the Manyland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Chevy Chase 1 Yes 2 No Maryland Montgomery Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 U.S.A. 20815 items 23s 3206 Winnett Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black White etc. 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after thygiene. 1 Navar Married 2 Married ☐Yas 2 No
☐Yes, Give Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 🗓 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hyglene important: if Hem 27 is marked other tha enty filury or other treumstic event, the Dance. Restaurant Owner Self-employed 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Angelos A. Bacas Doula Metrakos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Chevy Chase, Maryland 20815 3206 Winnett Road Katherine P. Bacas / Wife 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 1999 Suitland, Maryland Cedar Hill Cemetery 5 ☐ Other (Specify) 4 Donatida 22. Name and Address of Facility DeVol Funeral Home 21. Signate unerel Service Licensee 2222 Wisconsin Ave., NW Washington, DC 20007 the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, sert tailure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical immediate Cause (Finel 1 Year Metastatic Lung Cancer disaese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be asscuted physician and the bunal-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 3 1 Yes 2 No 3 Probably 4 Unknown signed b P 24b. Were sutopsy findings aveilable prior to Completed 24a. Wes an eutopsy been s completion of cause of death? has 1 TYes 2 No 1 □ Vac 2 □ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

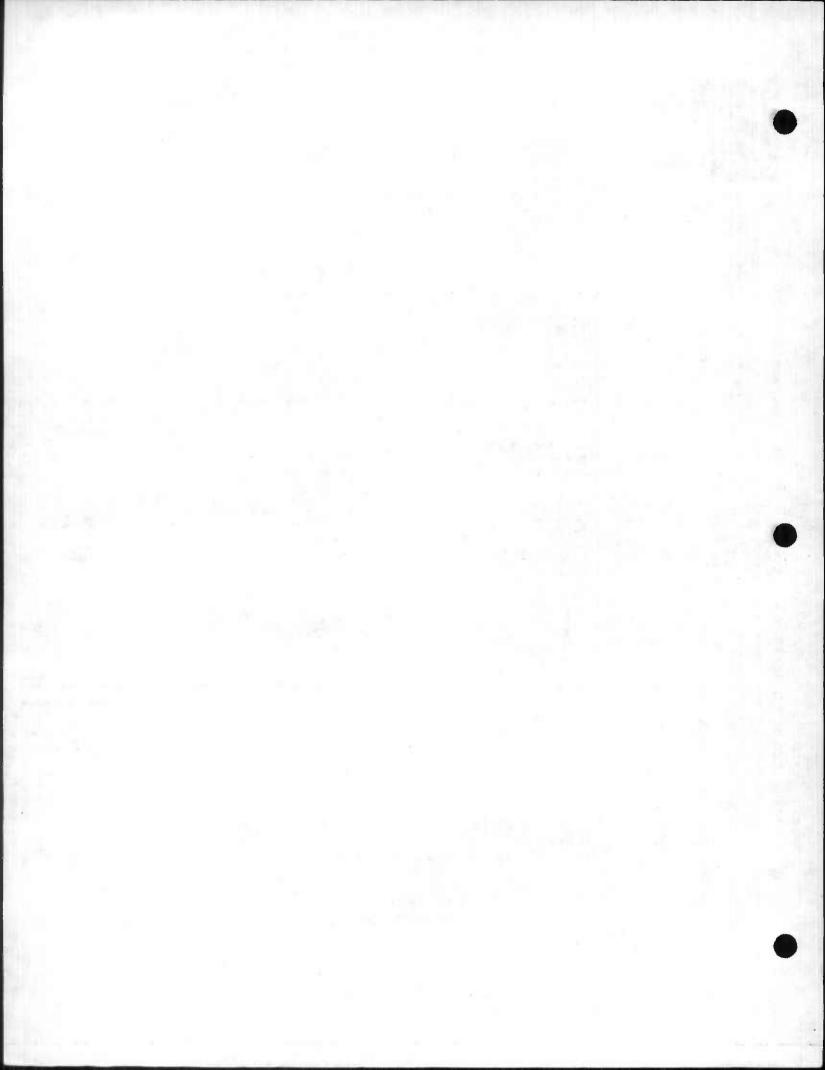
To the Funeral Director: After this certific. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Anesidence 6 Other (Specify) To 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of Certification: 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No invastigation 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12890 September 28, 1999 and acciress of parson who completed cause of deeth (Item 23a) (Type, Print) 5410 Connecticut Ave., NW #117 Washington, DC 20015 Wiseman, M.D. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State SEP 29 1999 Registrar



State of Maryland / Department of Health and Mental Hygiene

	4 December News (First Alfolds)	-41	(Certificate of	Death		Reg. No.		107 (0)
Physician	1. Decedent's Neme (First, Middle, La.					2. Date of De Month	Day	Year	3. Time of Death
/Medical	Donald Roy Ba						ber 27,		8:14 AM
Examiner	4e Facility Name (If not institution, give	*			4b. City, Town, or L	ocation of Deat	4c. Coun	ty of Death	
	Suburban Hospi			N. M. M. M. M. M. M. M. M. M. M. M. M. M.	Bethesda			gomer	2
Funeral Director	5. Social Security Number 480-14-4215 Usual Residence of Decedent	ex M 2 F 7. Age (f	77 Y	Monthe Dave		8. Date of Bir (Month, Da April	th ly, Year) 19, 1922	9. Birthp Court I OW	lace (State or Foreightry) 12
d 2 should be filed within 72 hours after death with the Maryland. It and Mental Hygiene. 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madeal Examinet must be notified at To Be Completed by Funeral Director.	10a. State 10b. County	10	Oc. City, Town	or Location				1	0d. Inside City Limit
vith the Mar or 28a-f s be notified Director	Maryland Montgome	ery	Bethes	da					1 ☐ Yes 2 🗓 N
or 28	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?
238	5500 Brite Drive			20817			United	Stat	es
r Neme 23a ploer must	11. Meritel Stetus	12. Wes Decedent Eve Armed Forces?	er in U,S.	13. Wes Decedent of If Yes, specify Cut	Hispanic Origin? (Sp	ecify Yes or No	- 14. Re	ce - Americ	
at, or items 23s or 28s-f show Examiner must be notified at by Funeral Director		1 X Yes 2 No	WWII	1 ☐ Yes 2 ☒ No		, , , , , , , , ,		www. Whi	
or than 'natural, the Wedless	15. Decedent's Ed (Specify only highest gra	lucation	16a. D	Decedent's Usual Occu Give kind of work done	pation	cina	16b. Kind of	Business/Inc	dustry
an alan	Elementery/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire	ed)			-	tment of
## P		5+		agement An	alyst		Financ	e & R	evenue
event Be	17. Fathar's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Suma	me)	
To de	Harrison Bailey				Rosella	Sears			
E	19e. Informent's Name/Relationship (Mailing Address (Stree					Code)
Important: If item 27 is any injury or other train 2005s.	Armand G. Bailey	(wife)	550	00 Brite Dr	ive, Beth	esda, M	laryland	208	17
\$ f	20a. Mathod of Disposition		20b. Piace of D	Disposition (Name of crematory or other pla	ice)	Date	20c. Location	- City or To	wn, State
# P	1 ☐ Buriel 2 【X Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify		Chesar	eake Crema	atory 9	-28-99	Bethe	sda. M	laryland
inju	21. Signatura of Funeral Service Licen	See		22. Name and Addr Rapp Fune	ess of Facility	D			
FES	1 Carala	\sim 0						1	1 2224
	23a. Part1. Enter the diseese, or companies, or heert failure. List only	olications that caused the	a death. Do no	933 Gist				Maryla	Approximete
sician	shock, or heert failure. List only	one cause on each line.						1	Interval Between Onset and Death
edical	Immediete Cause (Final	Cont	G11	Anoro-L	10			i	UPAD
miner	disease or condition resulting in deeth)	· CIANI	CEII	ARIEIGIN	7			1	FLORK
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s the burlst-transit	Sequentially list conditions	b	e to (or es a co	usednesce ut).				1	
E X	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0. 00. 00.						
physician and stransit the burdst-transit and burdst-transit and burdst-transit sellcal Examir	fuet miliefed exeuta	C. Due	e to (or es e co	nsequence of):				-	- 103
	resulting in death) Last							i	
for use a		d						1	
d for	Part II. Other significant conditions of	patributing to death but n	not resulting In t	he underlying cause of	iven in Pert I	23h Did	tohacco usa c	ontribute to	the cause of deat
detached for use	Tarin one agrinoant conditions of	online and the second s	iot resulting in t	rio unconying couse gi	VOI 11 1 01(1)		Yes 2 No		bably 4 Unkno
be det						,,,	100 2010		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
						24a. Wes	an autopsy		ere autopsy findings
Completed						pend	ormed?	CO	ailable prior to mpletion of cause death?
page 2						10	Yes 200No		Yes 2□ No
Be Co	25. Was case referred to medical				00 01 (0			1	J Tes 2LI NO
	examiner?	Hospital:	Ween.	OI - OI	26. Place of Deal				
rel dire	27. Manner of Death	1 Inpatient	2 ER/Outp	atient 3LI DOA	4 LI Nursing Ho		how injury occ		y)
After funeral formal fo	1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	ear) Inj	ury Wo	ork?]Yes 2 □ No				
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	30. Neme and address of person who		h (Item 23a) (T	ype, Print) Gabr	iel A. Be	rrebi,	M. D.	カスラ	
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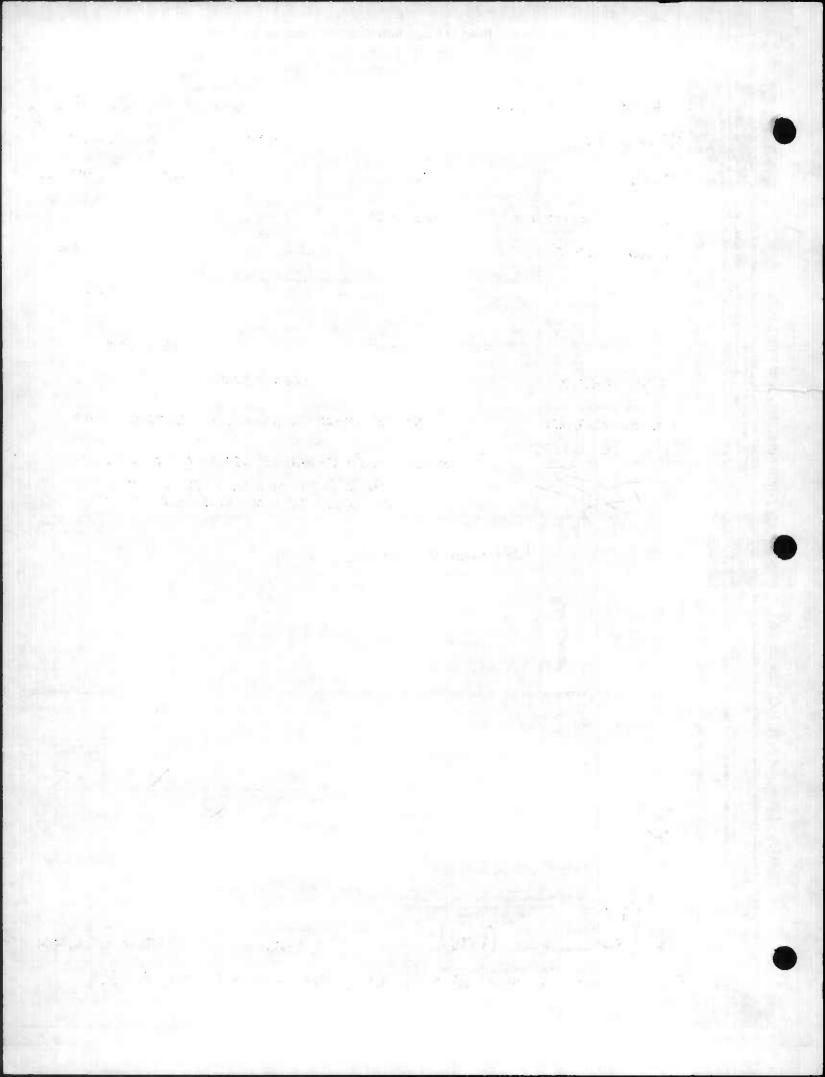
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Day SEPTEM OUR **Physician** 430 I. BLYUMINA EUKA 1999 · /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva straat end number) 4c. County of Death **Examiner** MONTGOMENS 95 DAWSON AUT 8. Date of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 1 M 2 N F Days Hours Min 76 Yrs. UKRAINE 03.01.1923 Director 215.43.7814 Usual Residence of Decedent with the Marylend 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limita r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No ROCKVILLE MONTGOMERY Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20850 95 DAWSON AVENUE permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Heelth and Mantel Hygiane. important: if itam 27 is marked other than "natural", or itema 23a and fujury or other traumatic event, the Medical Examiner marks once. Funeral 14. Race - American Indian. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. WHITE 1 Navar Married 2 Married 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 Yas 2 No Baltimore, Maryland 21215-0020 Specify Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Giva kind of work dona during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (14or 5+) DENTIST DENTISTRY 18. Mother's Name (First, Middla, Maiden Surneme) ROSA SHUYDKO 17. Father's Neme (First, Middle, Last) Be IISSAC REMENICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 788 PRINCETON PL, ROCKVILLE, MARYLAND LEO BLYUMINA/SON 20b. Placa of Disposition (Neme of cemetery, cremetery or othar place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 Burial 2 Semation 3 Removal from State MOUNT COMFORT CREMATORY 9.29.99 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sevice Licenses 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heet failure. List only one cause on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) OF Examiner Due to (or as a consequence of) Examiner that the death certificate be executed ettending physician end for use as the burial-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consaguance of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2000 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy Completed pege 2 hes 1 Yes 2 Mo certificate or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Sesidence 6 Other (Specify) 70 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death funeral 28d. Describe how injury occurred 28e. Dete of Injury (Month, Dey Year) 28h. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation after death. 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours a Hospital To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as steted.

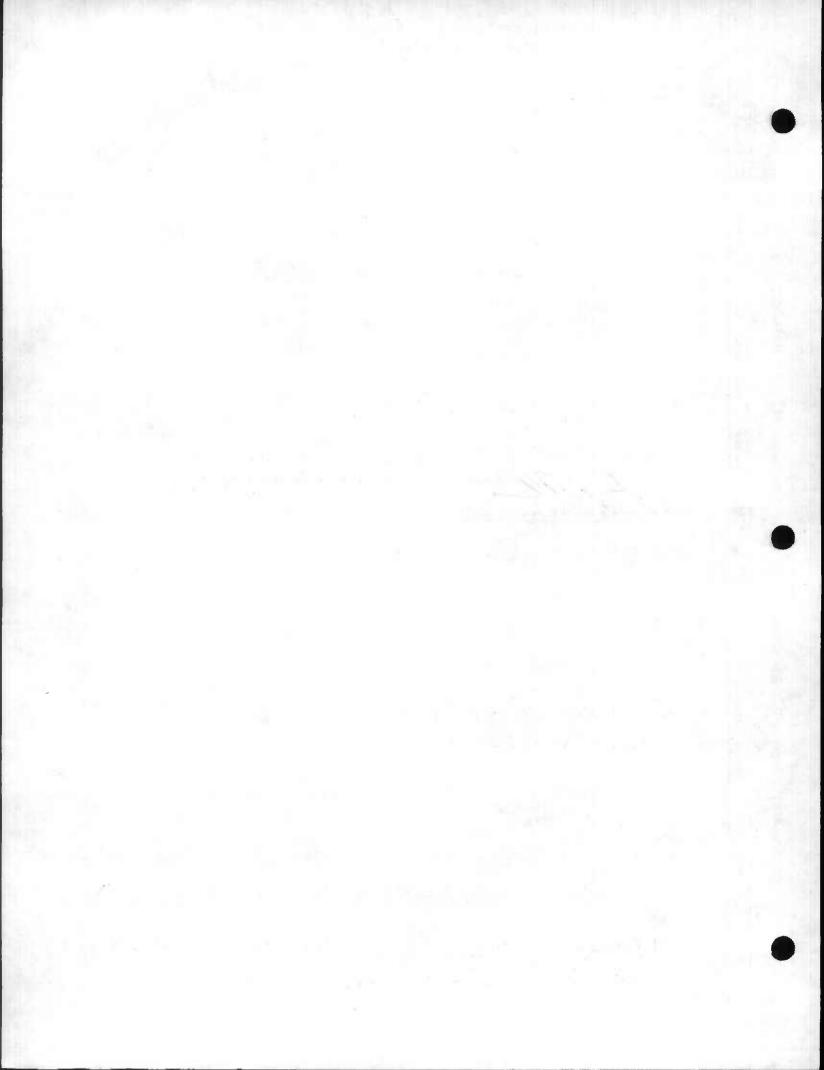
Control the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifie edical To the Hosp within 24 ho To the Fune completely fi (Check of one) 29d. Data signed (Month, Dey, Year) 29b. Signati d title of certifier 29c. License number 56875m800 26,1999 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARCIT. WAS GOLDS, MO. 11725 POCKARUS PIER LOCKVILLE, MO LOSSI 31. Data filed (Month, Day, Year) 32. Registrar's Signeture State SEP 3 0 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Mary		ertificate of			g. No.	31919
Dhuaisian	1. Decedent's Name (First, Middla, Last,					2. Data of Death Month		3. Tima of Death
Physician /Medical	Thomas Phillips B	rewer					1999	05:21am
Examiner	4a Facility Nama (If not institution, give				4b. City, Town, or Lo	ocation of Death	4c. County of	
	Holy Cross Hospit	al			Silver Spi		Montgo	omery
Funeral	5. Social Security Number 6. Sec	x 7. Aga (h ☑M 2□F	n yrs. last birthda	y) If Under 1 Yeer Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey,	Year)	Birthplace (Stete or Foreign Country)
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p a	Usual Residence of Decedent 10a. Stata 10b. County	10	c. City, Town or	Location				10d. inside City Limits
f show	Maryland Montgomer		Silver S					1 ☐ Yes 2 No
with the Maryland a or 28a-f show the notified at	10e. Street and Number	У .	SITAGE 2	10f. Zip Code		10	g. Citizen of Wh	**
Việt V	13767 Notley Road			20904				
free death with the Ma r thems 23s or 28s-fs sing must be noticed funeral Director		12. Was Decedent Eve	r in U.S. 13		Hispanic Origin? (Spi	ecify Yes or No-	United 14. Raca	States - American Indian,
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Maryland 2 should the and Ment of The marked traumatics	19a. Informent's Neme/Relationship (Ty			The second second	end Number or Run			
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Limen ment: bant: jury	4 ☐ Donation 5 ☐ Other (Specify)			ke Cremate				Le, Maryland
Baltimore, pemit. Peges 1 er Department of Hee Important: If Itan 2 eny Injury or other page.	21. Signeture of Funeral Service kings	MOC MOC	956		ess of Facility eral Servi Avenue, S			Maryland 20910
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(o	30. Name and address of period, who co Barry Rubin MD	mpleted cause of death 10801 Lock			oring Md 2	0901		
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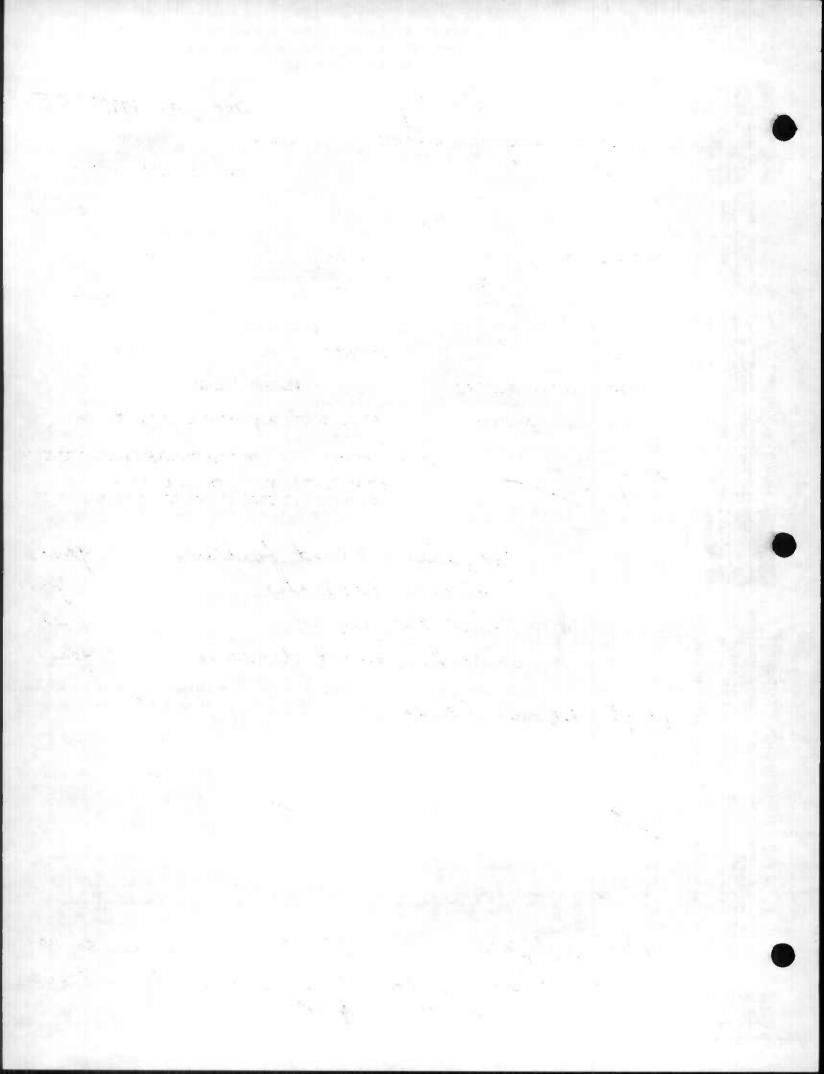


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death ✓ Month 15ROL **Physician** rep 30 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner & REHABILITATION CENTER HOWARD COLUMBIA LORIEN NURSING If Undar 1 Yaar If Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) JULY 21, 1 Birthplace (Stata or Foreign Country)
 NEW YORK 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days 1912 Director 094--32-5421 Usual Rasidance of Decedant with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at ₩ Yas 2 No Director COLUMBIA HOWARD 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda U.S.A. 21044 Funeral 6334 CEDAR LANE death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11. Marital Status Biack, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 XNo Baltimore, Maryland 21215-0020 Specify: Specify ò 3 AWidowed 4 □ Divorced WHITE Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) and Mental Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 10 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be f Department of Health and Mental is Important: If item 27 is marked of REBECCA WILLET (UNASCERTAINABLE) WILLIAMS 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 11866 BLUE FEBRUARY WAY COLUMBIA, MD 21044 SUSAN L. BAKER/DAUGHTER 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Locetion - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 20 4 Donation 5 Othar (Spacify) 10/3/99 PINELAWN L.I. NEW YORK NEW MONTEFIORE 21. Signature of Femoral Septice Licepton 22. Name end Addrass of Facilit DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 r complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, in only one cause on each line. Approximata Intervel Between Onsat and Daath **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examiner ician and burial-trans Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Cause (Disease or injury that initiated avants rasulting in daath) Last physician the bunal Physician/Medical - BSI Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Wara autopsy findings svailable prior to 24a. Was an autopsy Completed complation of causa of death? 2 1 No 1 ☐ Yas 2 ☐ No 25. Was case refarred to medicel axaminar? Be 28. Place of Daath (Check only one) Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Daeth funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? 5 Panding Invastigation 2 No death. 1 Yes 2 Accident ofter deat Director: 6 Could not ba 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 - Homicida ò 24 hours e Hospital Medicai 29a. Certifier 1 Certifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. within 24 hor To the Fune completely fi 2 Madical Examinar: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. (Check only one) the th 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. Licansa number 2 ptember 30, 1999 cause of deeth (Itam 23e) (Type, Print) 30. Name and eddress of person who complete 21042 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura

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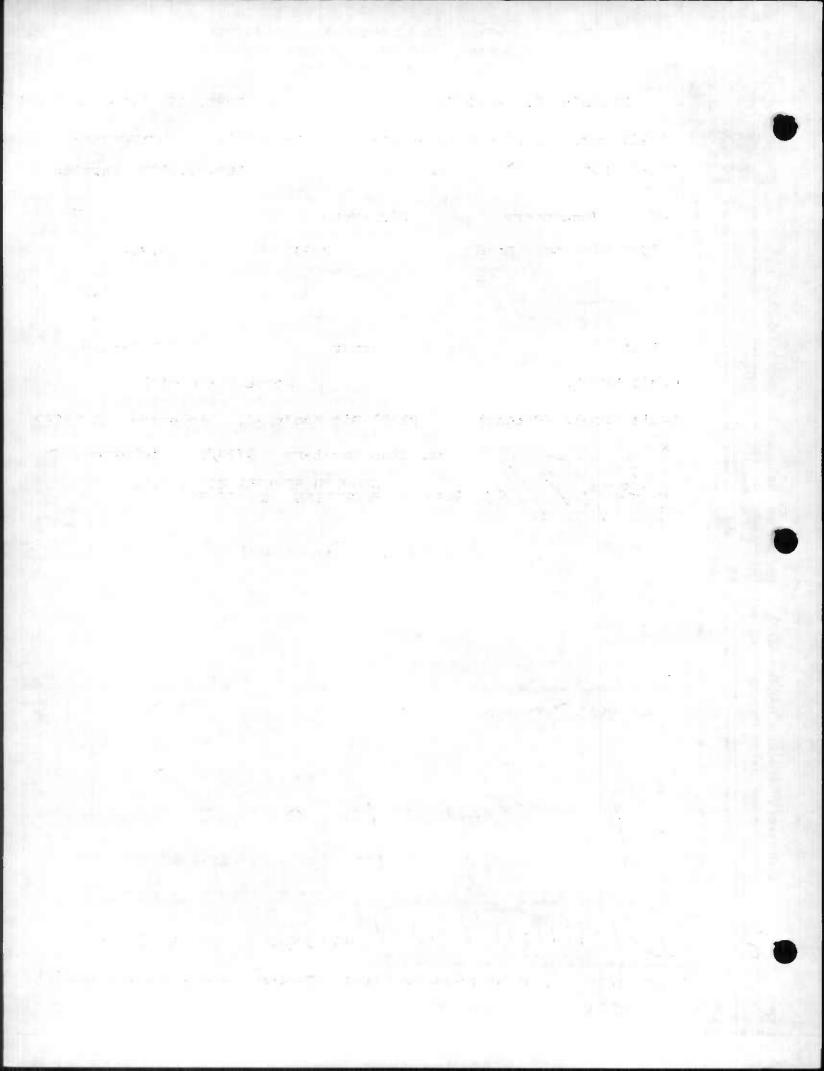


State of Maryland / Department of Health and Mental Hygiene

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22. Name and Address of Fectiny SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD. 20850 Approximate Consequence of the Spease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and the consequence of the subject of the su		PL Buriel 2 Cremetion 3 Litemovel from State	_			
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30. Name end eddress of person who completed cause of death (Item 23e) (Type Print) AUSH MACAR, NO 13219 Fraceurum BARL Trackets Communication LLD 2087	ertifica	determined 200. Flece of injury - At nome, tarm,	street, tactory, office	28f. Location (Stre City or Town,	eet end Number or Rure Stete)	el Route Number,
29b. Signature and hale of certifier 29c. License number 45 12 80 9-27-99 30. Name end eddress of person who completed cause of death (Item 23e) (Type Print) AUSH DASCAR, 10 13219 Fraceuture BASIL Transfers Screense bown 440 2087	dicai C	(Check only 2 Medical Examiner: On the basis of examinetion end/or				
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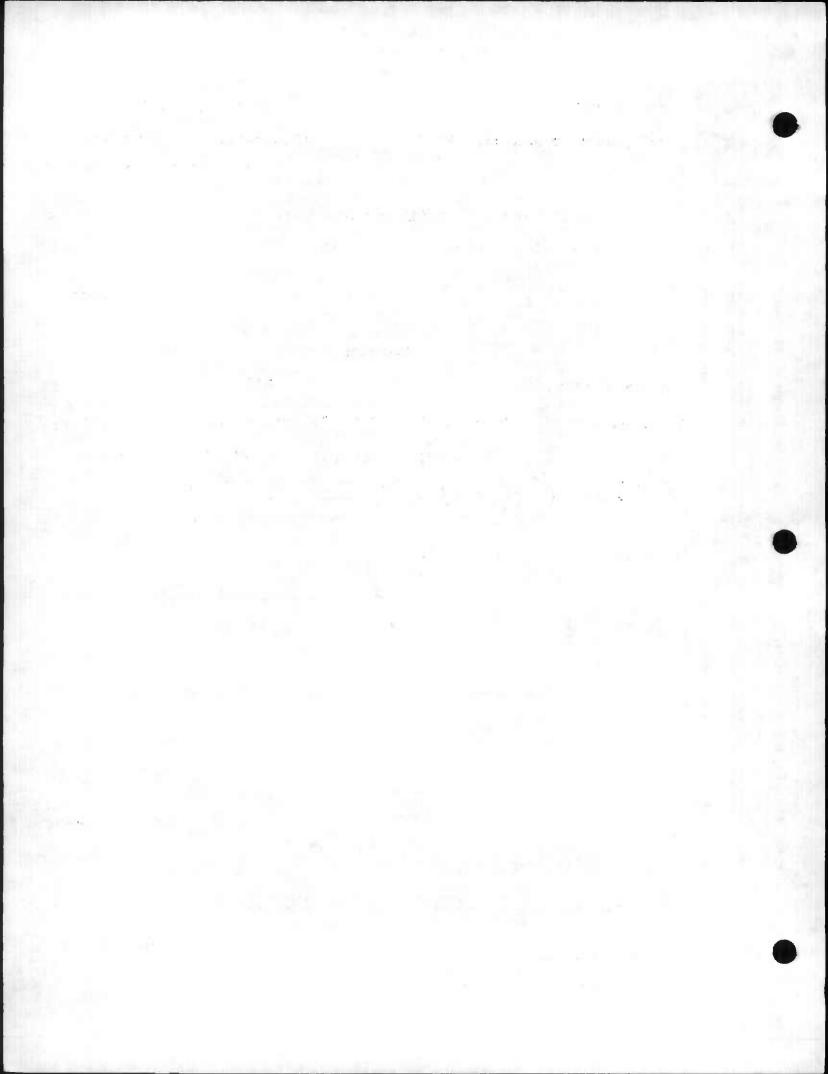
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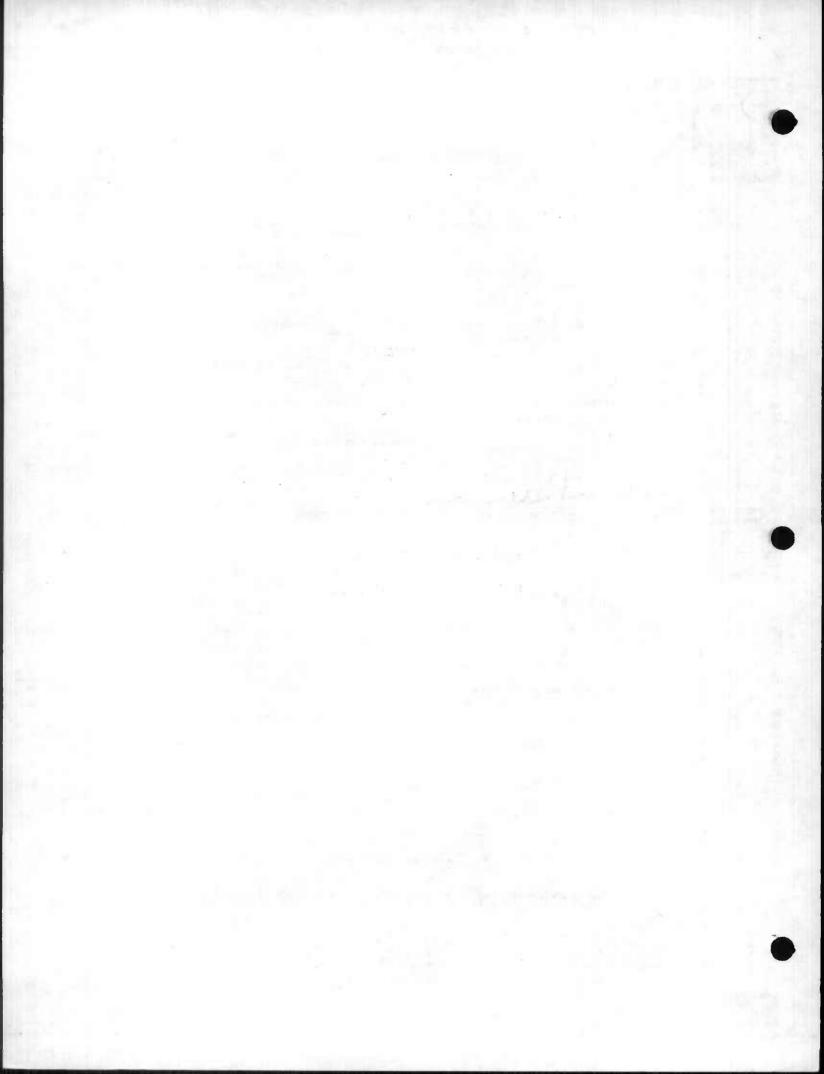
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPT. 26, 1999 0745 JOE LOUIS BROWNING /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg 427 Muddy Branch Rd., #104 MONTGOMERY Months Days Hours Min. June 21,1939 9. Birthplace (State or Foreign North) Days North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 110 M 2□ F 60 240-60-7190 Director Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10s. State 10b. County 10d. tnside City Limits r than "natural", or itama 23a or 28a-f ahow toa Madical Examinar must be notified at Gaithersburg 1 ☐ Yes 2 No MD Montgomery Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 U.S.A. 19812 Wheelwright Drive death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ※ No
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Bleck, White, etc. 72 hours after Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 8th Warehouseman Crown Supply Co. permit. Pages 1 and 2 should be file Department of Health and Mental Hyy Important: If item 27 is marked othe any injury or other traumatic avant, bace. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Linwood Browning Aline Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 8 7 8 19a. Informant's Name/Relationship (Type, Print) 427 Muddy Branch Rd., Gaithersburg, MD Angel R. Browning (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 🛣 Removel from State Cofield Funeral Home 9/29/99 Weldon, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part I. Enter the drams, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart falling. List only one sause on each line. Approximete nterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Emphysemia Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to for as a consequence of: Box 68760. Physician/Medical Due to (or as a consequence of) 188 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yea 2 No this cartificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Yes 2 No 2 he Hospital or Attanding PI in 24 hours after death. Ne Funeral Director: After th stately filled in by the funeral funeral Home 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of trijury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner steted. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 015236 ONE SEPTORBOR 28, 1991 30. Name and address of person who completed cause of death (trem 23a) (Type, Print) CAM MALGOUS, MO. 11125 BOCKETUS HATE, HOCKETUS MO LOSE 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State SEP 29 1999 Dener Registrar



		State of t	Maryland / De <i>C</i>	ertificate of		-	Reg. No.	3136	13
	1. Decedent's Neme (First, Mide	dle, Last)				2. Date of De		3. Time o	/ Death
Physician	ELIZABETH J.	DDIINCADT				Month SEPTEME	Dey 3至2 23 (Year	O PM
/Medical	4e Facility Neme (If not instituti		er)		4b. City, Town, or Le			10 0	O EE.
Examiner	GENESIS LAYHI				CTIVED CD	DINC			
	5. Social Security Number		Age (In yrs. last birthda	(au) If Under 1 Year	SILVER SP		MONTGO		or English
Funeral		1 M 2 F	Vm	Months Davs		8. Date of Bir (Month, Da	y, Year)	9. Birthplace (State Country)	
Director	577-30-5792 Usual Residence of Decedent		74			7/26/2	.5	VASHINGTON	, DC
1	10a. Stete 10b. Count	ly	10c. City, Town or	Location				10d. Inside C	ity Limits
therm 23s or 28s-f show ther must be notified at Funeral Director	MD MONT	GOMERY	STLVER	SPRING				1 ☐ Yes	2(No
be notified Director	10e. Street and Number		023,31				10a. Citizen of W		41
				10f. Zip Code				mat Country?	
rai	3340 HEWITT A			20906			USA		
Funeral	11. Meritel Stetus	12. Wes Decede Armed Force	as?	Wes Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp van, Mexican, Puerto	ecity Yes or No Rican, etc.)		e - American Indian, k, White, etc.	
y F	1 Never Merried 2 Me	If Yes Give	No	1□Yes 2☑No	Specify:		Specify	WHITE	
d by	3 ☐ Widowed 4 ₹ Divorce	Year or Dete	os:	16				WILLE	
Completed		ent's Education est grade completed)	(G	cedent's Usual Occupive kind of work done	during most of work	ing	16b. Kind of Bu	siness/Industry	
npi	Elementery/Secondery (0-12)	College (1-4	or 5+)	e. DO NOT use retire	ed)				
Co		2	НО	MEMAKER			OWN HO		
Be	17. Father's Name (First, Middle	, Last)			18. Mother's Nam	a (First, Middle	Maiden Sumam	Θ)	
10	EDWIN JOHNSO	N			EMILY	ROWLEY			
	19a. Informant's Neme/Reletion	nship (Type, Print)	19b. M	ailing Address (Street	t and Number or Run	al Route Numb	er, City or Town,	State, Zip Code)	
	KAREN TAYLOR	R/DAUGHTER	9 F.	AIRDALE CI	r., SILVER	SPRING	, MD 209	905	
	20e. Method of Disposition	- Local Contraction Contract	cometen o	sposition (Name of crematory or other pla	ace)	Dete	20c. Location -	City or Town, Stete	13.
	1 ☐ Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (3 Reproval from Sta	100	FORT CEMET	10	/27/99	ALEXANDI	RTA WA	
	21. Signeture of Funeral Service	V 11							
any injury or or	ALL	11.11	1	22. Name end Addre DANZANSKY	GOLDBERG	MEMORIA	L CHAPET	LS, INC.	
	Lecuna	ration		1170 ROCKV					
	23e. Pert1. Enter the disease, of hock, or heart failure. Lis	or complications that caust only one cause on each	sed the deeth. Do not h line.	enter the mode of dyi	ing, such as cardiac	or respiretory a	rrest,	Approxime Intervel Be	tween
ian								Onset and	Death
al er	Immediate Cause (Final disease or condition	. ASPTR	ATION PNE	UMONIA				1 WEE	K
	resulting In deeth)	0	Due to (or as a con						
i e		- NON-S	MALL CELL	CARCINOMA	LUNG			6 MON	THS
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Ě	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	,							
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2	resulting in death) Lest								
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Physician/Me	orm other alguments outlot	ions continuously to coul	TOOL TOO TOO THE TOO	o onconying cause gi			Yes 2 No		Unknown
by P					36		100 20110	7 A	
Q Q						24a. Was	an autopsy	24b. Were autopsy	findings
Completed							med?	available prior completion of	
E D								of death?	
S						10	Yes 2 No	1 ☐ Yes 2 ☐	No
a	25. Wes case referred to medic examiner?				26. Place of Deat	th (Check only	one)		
P	1 ☐ Yes 2 ☐ No	Hospitel: 1 🗆 Inp	atient 2 ER/Outpa	tient 3 DOA	her: 45 Nursing Ho	ome 5 Resi	dence 6 □Oth	er (Specify)	
	27. Menner of Deeth	28a. Dete of I	njury 28b. Time		iry at	28d. Describe	how injury occurr	ed	
Medical Certification:	1 Natural 5 Pend 2 Accident Inves	tigetion	, , , , , , , , , , , , , , , , , , ,		Yes 2□No				
Certification:	3 Suicide 6 Could 4 Homicide deter	mined 288. PI808 Of	Injury - At home, farm,	street, factory, office				er or Rural Route Nur	nber,
e T	4 LI Homicide	building,	efc."(Specify)			City or To	wn, State)		
	29e. Certifier 1X Certify	ing Physician: To the be	est of my knowledge, de	eath occurred at the ti	ime, date end place.	and due to the	cause(s) and ma	nner as stated.	
edical		Examiner: On the basis	s of examination and/or						s)
2	29b. Signeture and title of certifi			29c. Licen	se number	T	29d. Date signed	(Month, Day, Year)	
	A	A ALO.	· coa	in					
	1 mec	- Ell	MONTH I	D382	262		24 SE	PTEMBER 99	
	30. Nama and address of person	The second second							
	DR. A. MENDHIE	RATTA 2401	RESEARCH B	LVD, ROCKY	VILLE, MD	20850			
tate	31. Date filed (Month, Day, Year	A.	istrar's Signeture	1					
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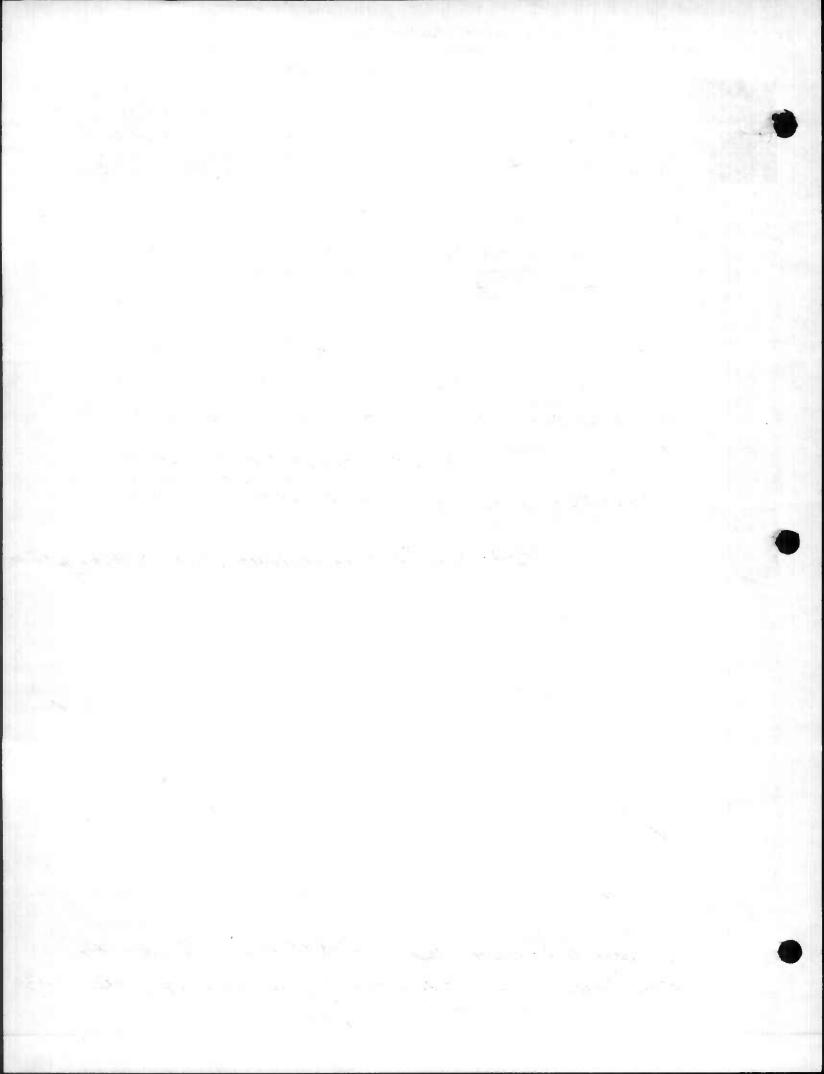


	E		State of Maryland /	Certificate of		Reg. No.	3 1984:
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/Medi Exami Funeral Director		4e. Facility Neme (If not institution, give s Malay d B 5. Social Security Number 6. Sex 220-01-2447	ay Nursing	Center	1 44 4 4	dge Doy Dete of Birth (Bronth, Dey, Year)	ty of Death Chester 9. Birthplace (State or Foreign Navy land
Maryland 14 show filed at	tor	Usual Residence of Decedent 10a. State 10b. County	nester 10c. City, To	wn or Location	ρ	10091100	10d. Inside City Limits
With the	Director	10e. Street end Number		10f. Zip Code	16.12	10g. Citizen o	What Country?
020 / us after death if, or thems 23 exeminer, mus	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yas, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cube 1 Yes 2 No	Ilspenic Origin? (Specifien, Mexican, Puerto Ric	y Yes or No- an, etc.) 14. Re Bi	aca - American Indien, ack, White, etc.
21215-00 d within 72 hou plens. r than "natura tha Medical E	Completed	15. Decedent's Educ (Spacify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occup (Give kind of work done life, DO NOT usa ratired DO MEST		16b. Kind of	Business/Industry The Family
tryfand thould be Illa d Mental Hy marked othe matic event,	To Be C	17. Father's Name (First, Middle, Last) WebStey 19a. Informant's Name/Relationship (Ty)	Stanley	b. Mailing Address (Street	18. Mother's Name (F		MPSON
nore, Ma ages 1 and 2 an		20a. Method of Disposition	Pennis 20b. Place comet	5/1 Dobsov of Disposition (Name of ery, crematory or other plea	n Street (Pambridge Dete 20c. tocation	Maryland 2/6/3 - City or Town, State
Battin permit. P Departme important any injury once.		21. Signeture of Funeral Service License	Henry	22. Name and Addre Henry F 510-Was	hington.	tome P.A. St. Cambri	s Island, MD 'dge, MD, 2161'
Physician /Medical Examiner		23a. Paft1. Enter the disease, or complished, or haart failure. List only on Immediata Cause (Final disease or condition resulting in death)	Resprige	Try for a consequence of):	rilen	٠.	Inlarval Batwean Onset and Death
Box 68760, ath certificate be executed uttending physician and for use as the burial-transit	n/Medical Examine	Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Diseasa or Injury thet initiated events resulting in death) Lest	Coronar	empty, consequence of: y are obtained using the	sema in die	ease.	years years
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To the Hos within 24 h To the Fun completely	Me	29b. Signeture and title of certification					red (Month, Day, Year)
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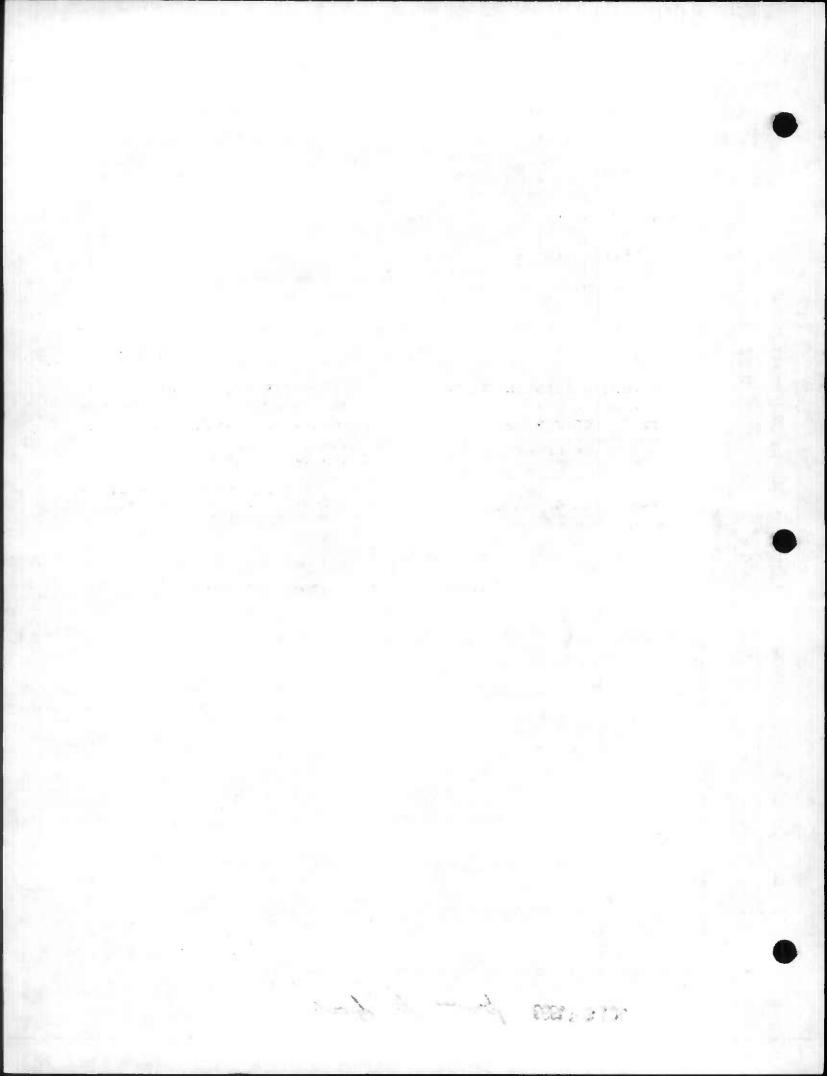
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/Medica		4e. Fecility Neme (If no						4b. City, Town, or L		er 27,1	. 777	
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Funeral Director		5. Sociel Security Number 213-70-82	227 1	Sex I□M 25F	7. Age (In yrs	s. lest birthdey) Yrs.	If Under 1 Yeer Months Deys		8. Dete of Birth (Month, Dey Feb. 1	, Yeer) 1958	9. Birthpiece Country) Maryla	(State or Foreig
		Usuel Residence of De	ecedent 0b. County		100.0	City, Town or Lo	ocation				104	anida Ola I Inda
e da la	5	MD	Dorch	ester	100. 0		adison		•			nside City Limit
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	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 Married		edent Ever in lorces?			Hispenic Origin? (Spen, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - American Ir ck, White, etc.	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death **Physician** ADELE ELLEN CHAMBERS OCTOBER 1, 1999 /Medical 6:10 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SACRED HEART HOSPITAL CUMBERLAND If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 10 M 2 F 70 Yrs. 215-26-6584 JULY 18,1929 MARYLAND Director Usual Residence of Decedent with the Merylend 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No MARYLAND ALLEGANY LAVALE Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1015 WEIRES AVENUE 21502 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 Never Married 2 Merried 1 Yes 2 No
If Yes, Give
Year or Dates: 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE P 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK GROCERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Peges 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Itam 27 Ia marked oth any injury or other traumetic avam Be JOHN THOMAS RUSSELL SMITH EFFIE MAE GARLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENT STOTLEMYER/SON 1015 WEIRES AVE., LAVALE, MD 21502 20e Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State O C T 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State SILBAUGH CREMATORY 6,1999 UNIONTOWN, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502 23a. Part1. Enter the disease, or complications that seased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final SHOCK CARDINGENIC ONE DAY disease or condition resulting in death) Examiner Due to (or as a consequence of): TWO YEARS BIVENTRICULAR CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last pue Due to (or as a consequence of): physician s the burial Box 68760 2 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Nos 2 No 3 Probably 4 Unknown been signed by should be detac NEUMONIA Records, à 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy EMPEREM A has page 2 The 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Department 2 ER/Outpatient 3 DOA To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital
 24 hours a
 Funeral 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) (and) Ween 037 417 OCTOBER 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) my VAMES R. MOEN, MD. 1068 NATIONAL HIGHWAY LAVALE MANELAND 21502 31. Date filed (Month, Day, Year) OCT 0 4 1999 32. Redistrar's Signature State Registrar

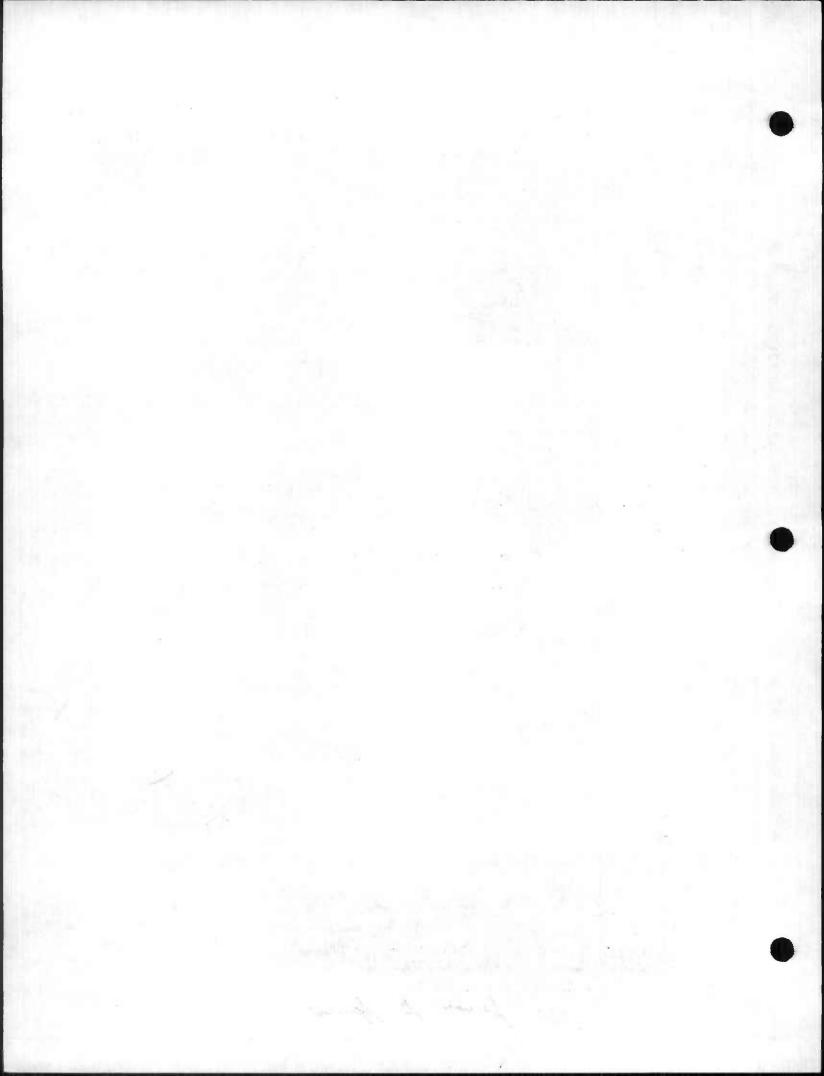


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	State of Ivi		Certificate of	Death	R	eg. No.	01301			
Physician	Decedent's Name (First, Middle, Last)				2. Date of Deal Month	th Day Ye	3. Time of Death			
/Medical	JAMES W. CONNERS		7		Oct. 3		9:00 p.m.			
Examiner	4a Facility Name (If not institution, give street and number)			tb. City, Town, or Li		4c. County of E				
-	MORAN MANOR NURSING HOME 5. Social Security Number 6. Sax 7. Ag	e (In yrs. last birth	1 4411 1 114	WESTERNPO	8. Date of Birth	ALLEGAN				
Funeral Director	214-30-9621 Usual Residence of Decedent	66 Y	Months Days	Hours Min.	Oct 19,	Year)	Birthplace (State or Foreign Country) MD			
ise death with the Maryland isens 23s or 28s f show first must be notified at Funeral Director	10e. State 10b. County	10c. City, Town					10d. Inside City Limits 1 X Yas 2 □ No			
or 28a-f s be notified	MD Allegany 10e. Street and Number	Cumber	10f. Zip Code			0g. Citizen of What				
O P	444			0			Country			
flar death of the flame 23 siner must Funeral	608 Maryland Avenue 11. Marital Status 12. Was Decedent	Ever in U,S.	2 150 13. Was Decedent of H if Yas, specify Cubi		ecity Yes or No-	USA 14. Race - /	American Indian,			
_ # # # P	Armed Forces? Never Married 2 Married 1 Yes 2 Yes 3 Widowed 4 Divorced Yaar or Datas:	No	If Yas, specify Cuba 1 ☐ Yes 2 🕱 No	an, Mexican, Puarto Specify:	Rican, atc.)	Specify:	White, etc. White			
2 hours	15. Decedant's Education	16a. D	ecedent's Usual Occup	ation		16b. Kind of Busine				
Maryland 21215-0020 42 should be filed within 72 hours at the and Mental Hygiene. 7 is marked other than "natural", or traumelic event, the Medical Exam To Be Completed by F	(Specify only highest grade completed) Elemantary/Secondary (0-12) Collega (1-4or 5	5+)	Give kind of work done ife. DO NOT use retired		ing	m:h				
d Hand	12 17. Father's Nama (First, Middle, Last)	Ket	ired Labore	18. Mother's Name	e (First, Middle, I	Timber Maiden Sumame)				
/land	Francis William Conners					(Hoadley)			
T T	19a. informant's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street			-				
	Patricia Dollysister	183	18 Platinum	Road, SW	: Rawli	ngs, MD	21557			
Ore Table	20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place		T .	20c. Location - City	y or Town, Stata			
Pages sent of nut: If Its	1 M Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify)		vn Memorial		10/07	LaVale, M	D			
Baltimore, permit. Pages 1 as permit. Pages 1 as important: if item; any injury or othe once.	21. Signature of Funaral Sarvica Licansee	100M-	22. Nama and Addra Scarpelli	ss of Facility						
	330 Badi Edwin San San San San San San San San San Sa	alle	Cumberland			1	Approximata			
Physician	23a. Part1. Entar tha diseasa, or complications that caused shock, or heart failure. List only one gause on each life						Interval Between Onset and Death			
/Medical Examiner	Immediate Cause (Final disease or condition	cute	Myaca	whial :	marc	tim	45 minu			
	rasulting in daath)	Due to (or as a co	nsequence 1):		1					
b # F	b									
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the deal y the at sched to hysici	Part II. Other significant conditions contributing to death be	ut not resulting in t	he underlying cause giv	an in Part I.	23b. Did to	obacco use contril	bute to the cause of death?			
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require been s should leted	History of 1	hyperte	ersion		24a. Was e perform		4b. Wera autopsy findings available prior to completion of cause of death?			
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of Vita Physician: this certific ral director,	examiner? 1 Yas 2 No Hospital: 1 Inpatie	ent 2 ER/Outp	atient 3 DOA Oth	er: 45 Nursing Ho	me 5 Raside	ence 6 Other (Specify)			
Vision o Attending Ph ordeath. ector: Atter th by the funeral	27. Manner of Death The Natural 5 Panding (Month, Day 2 Accident Investigation	ry y Year) 28b. Tin inju	iry Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred				
क विस्तृत प्र	2 □ Suicido 6 □ Could not be		n, street, factory, office		28f. Location (Si City or Town	treet and Number on, Stata)	or Rural Route Number,			
To the Hospital within 24 hours a To the Funeral completely filled	29a. Certifier (Check only one) Certifying Physician: To the best of and manner ste	axamination and/	death occurred at the tir or Investigation, in my o	ne, data and placa, pinion, death occur	and due to the cred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)			
To the comp	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (A	fonth, Day, Year)			
	1/11-1)		D2124	4		Oct.	4 . 1999			
wi	30. Name and address of person who completed cause of d	aath (Item 23a) (T				oct.	, 1999			
4	Dr. Jesus Tan; Frostburg Pl			21532						
State	31. Date filed (Month, Day, Year) 32. Registro	ar's Signatura								

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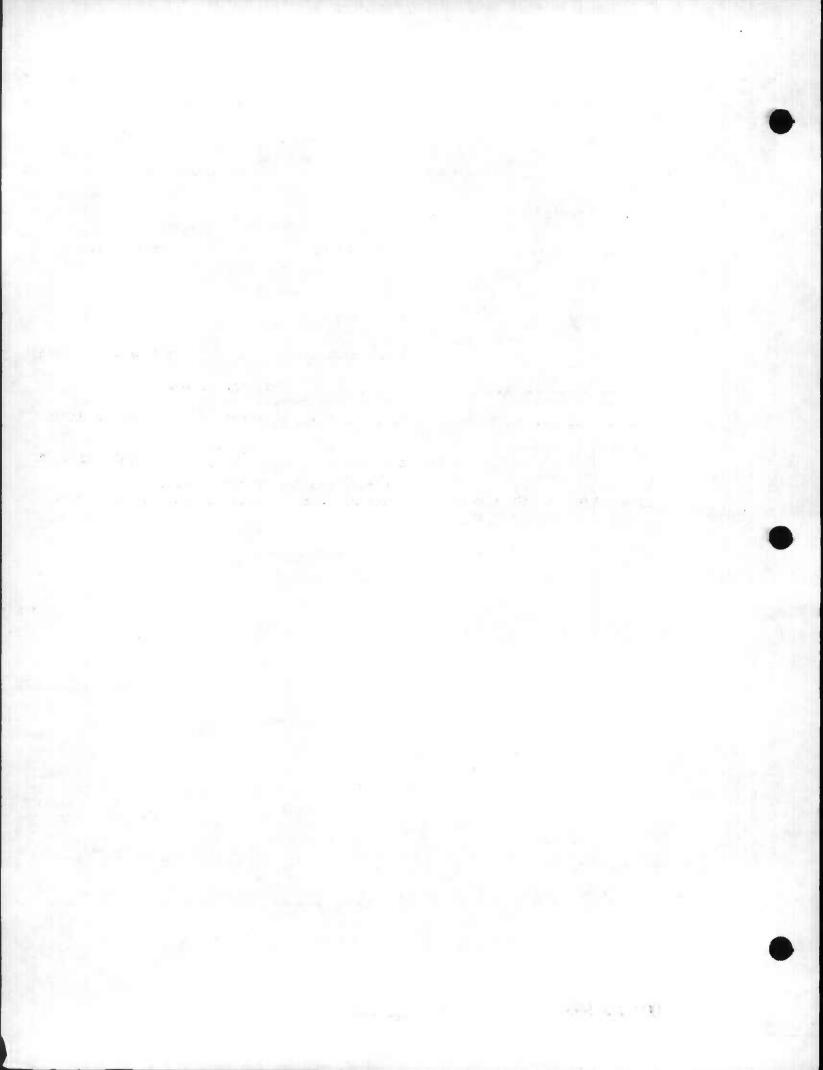
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State of Maryland / Department of Health and Mental Hygiene

3 989 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Yeer September 29, 1999 **Physician** 1810 P Donna Lee Collins /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil 309 Biddle Street Chesapeake City If Under 1 Yeer Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In vrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months 1 M 2 TF Director 213-66-6676 September 27, 1953 Maryland the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or flams 23e or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 □ No Elkton Cecil Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 United States 223 Douglas Street Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry be filed within 7 ial Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Municipal Government Finance Officer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Virginia C. Lee Lewis A. Collins, Jr. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) P.O. Box 503, Chesapeake City, Maryland 21915 Lewis A. Collins, Jr./Father 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) October Chesapeake City, MD Bethel Cemetery 2,1999 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. mark 103 W. Stockton St., Elkton, Maryland 21921 owed. 23a. Part1. Enter the disaasa, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batw Onset and Death **Physician** Immediata Cause (Final disease or condition rasulting in death) /Medical Medastatio Cancer -Examiner Due to (or as a consequence of) Examine lician and burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to for as a consequence of: Box 68760 physician 8 Physician/Medical 2 Due to (or as a consequence of): ï 85 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ž 1 Yes 2 SNo 3 Probably 4 Unknown igned by Division of Vital Records, ğ Completed 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? continents has page t ☐ Yes 2 million 1 ☐ Yes 2 DicNo 25. Was case referred to medical 89 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Flesidence 6 Other (Specify) Parents 1 Inpatient 2 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this Residence 27. Manner of Death 26d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: Injury at Work? Attac **5dNatural** 5 ☐ Pending investigation 1 Yes 2 No Annidant after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, fay building, etc. (Specify) it, factory, office -4 Homicide To the Hospital o within 24 hours at To the Funeral Di edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

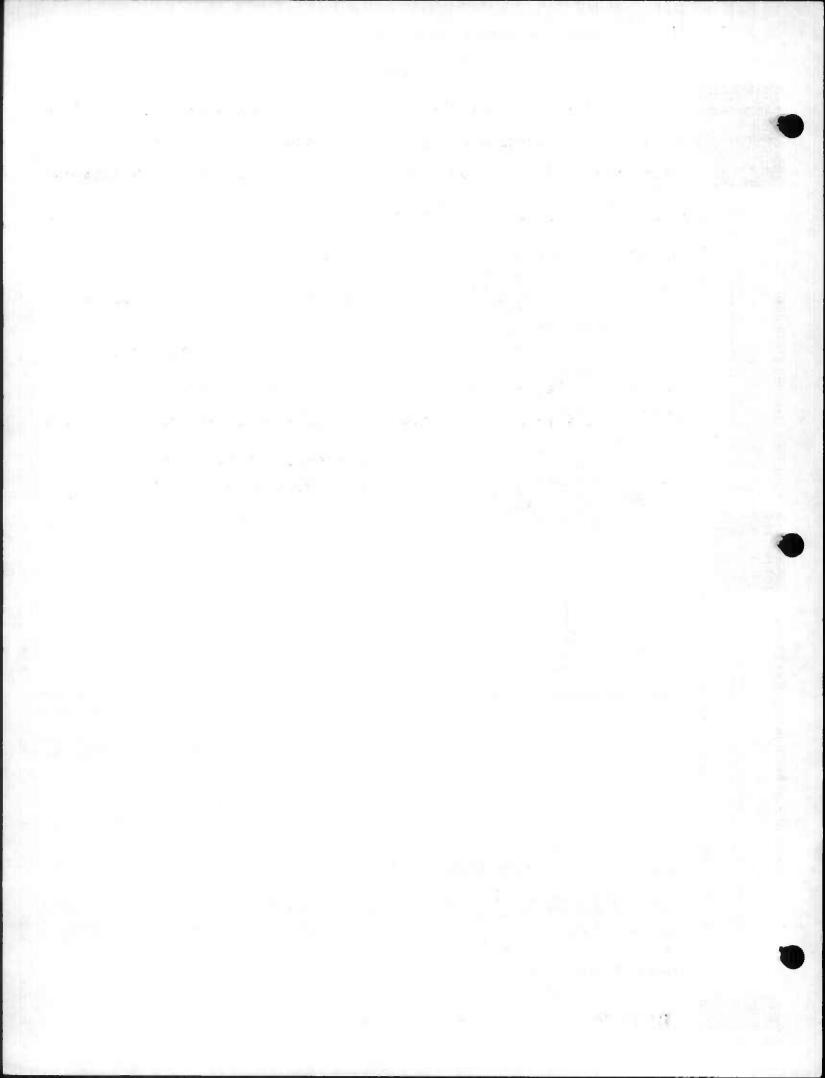
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifler 29b. Signature and title of obfillier 29c. License number 29d. Date signed (Month, Day, Year) (Type, Print) (Type, Print) MA DOJ #2. Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

					Ce	ertificate of	Death		Reg. No.	10	0122	U
	Dhi.al		1. Decedent's Name (First, Middle, Las					2. Dete of De Month		Yeer	3. Time of D	eath
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テ	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Deat	h 4c. Count	y of Deeth		
			MAGNOLIA HALL				Cheste		Ke	nt		
	Funeral Director		5. Sociel Security Number 222-24-0900 Usuel Residance of Decedent	ex 7. Aga (in yrs. 85	last birthdey Yrs.	Months Deys			th ey, Year) 914	_ Cqui	pieca (Stata or ntry) aware	Foreign
	yland		10e. Stete 10b. County		ty, Town or L						10d. inside City	Limits
	e Ma	ctor	Del. New Cas	stle To	ownse	na					1 ☐ Yas 2	2 🖾 No
	th with th	Funeral Director	10e. Street and Number 329 VanDyke-Mo	d. Line Rd.		10f. Zlp Code 1973	4		10g. Citizan of USA	Whet Cou	ntry?	
Baitimore, Maryiand 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, fre Medical Examines rout be notified at any injury or other traumatic event, fre Medical Examines.	þ	11. Marital Status 1 Never Merried 2 Married 3 Muidowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Yaar or Datas:	l,S. 13.	Was Decedent of If Yas, specify Cub 1□ Yas 2⊠No	oan, Mexican, Puer	Specify Yas or No rto Rican, etc.)	Bia	ce - Americk, White,		
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ore,	of Hear Item		20a. Method of Disposition		Place of Disp	osition (Neme of emetory or other ple	ece)	Dete	20c. Location	- City or T	own, Stete	
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	/Medical Examiner		Immediate Cause (Fine) disease or condition rasulting in death)	· Cerebr	Nas C	ulas a	ccider	t		i		
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	execu n and al-tra	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying	Dua to (d	or as e conse	quenca of):				i		
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m m	death	Physician/	Pert II. Other significant conditions co	entributing to death but not res	ulting in the	undartying cause g	iven in Pert I.	23b. Dld	tobacco use co	ontribute t	o the cause of	death?
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2	after Direct	ertit	4 Homicida datarmined	building, etc. (Specif	у) У)	rieet, rectory, onice		City or To	wn, Stete)	oor or righ	ai riodia ridino	D1,
	To the Hospital or Attending Physicisn: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical C	29a. Cartifier (Check only one) 1 Certifying Phy	raicien: To the best of my kno iner: On tha basis of examine end menner steted.	wiedga, dea tion end/or in	th occurred at the to	ime, dete end plec opinion, death occ	a, end due to the urred et the time,	cause(s) and m dete end plece,	annar as a	stated. to the cause(s)	
	o the	Me	29b. Signeture end title of certifler	The state of the s			sa number		29d. Date signe	ed (Month,	Dey, Year)	
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	10		30. Name end eddress of person who c	complated cause of deeth (Iter	n 23e) (Tvpe	Print)						
	10		Heather Morphy	MD - ROHND =	TOP PR	FESCONAL	BLDG -C	CHESTER	TOWAI	Mn		
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	Registr	ar	OCT 0 4 1999	Denne B	. 10	acks						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 Decedent's Name /First, Middle Last) 2. Dete of Death 3 Time of Death **Physician** September 28, 1999 1:55 A.M. Cleo H. Campbell /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
July 27, 1910

9. Birthplace (Stete or Foreign Country)
South Carolina 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 251-09-5118 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effar death with the Maryland Department of Health and Mental Hygiens. Important: If Itam 27 is marked other than "natural", or herm 23a or 28a-f show any injury or other treumatic avant, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17832 Mill Creek Drive 20855 Funeral United States Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3⊠Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Resident Manager Rental Apartments 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Stephen Hollis Tina White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Steve Campbell/Son 17832 Mill Creek Drive, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 10/1/99 Rockville, MD. 22. Name and Address of Fecility DeVol Funeral Home ure of Funeral Service License ew 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each tine. Approximete Interval Between Onset and Death **Physician** a Anterior Wall A /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Hospital or Attanding Physician: The lew requires that the death certificate be associated the fours after death.
 Funeral Director: After this certificate has been signed by the attending physician every filled in by the funeral director manning. Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of): 23b. Dfd tobacco was contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings evailable prior to 24a. Was an eutopsy Completed completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 21 No 10 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manger of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not ba 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of portifing SEPTEMBER 28, 1999 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wielebinski, MD 18550 Office Park Dr. Montgomery Village, MD 20886 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **SEP 30** 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedant's Name (First, Middla, Last) 3. Time of Death SEPTEMBER 24, 1999 **Physician** 0200 CAMPBELL DOUGLAS F. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 1003 EAST -WEST HIWAY TAKOMA PARK PRINCE GEORGES If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days 1₩ M 2□ F Months Hours Yrs. 66 VIRGINIA 577-42-3905 Director Usual Residence of Decedant filed within 72 hours after death with the Maryland r 28a-f show inotified at 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo MD. PRINCE GEORGES TAKOMA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be r 1003 EAST WEST HWY. 20912 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian Black, White, etc. 1 X Yas 2 □ No If Yas, Giva Year or Datas: KOREAN 1 □ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: ģ 3 ☐ Widowad 4 ☐ Divorced WHITTE "natural", Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Dacedant's Education (Spacify only highast grada complated) Collaga (1-4or 5+) Elementary/Secondary (0-12) Hygiene. AUTO PARTS SALES 11 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumema) Peges 1 and 2 should be filk ment of Health and Mental Hy ant: If Item 27 is marked oth ury or other trsumatic eventury or other trsumatic eventual properties. Be **JESSE** CAMPBELL ELTON GLADWELL 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) CAMPBELL/WIFE AS ITEM ANNA L. 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If any Injury or once. MARYLAND VETERANS CEMETERY 9/30/99 CHELTENHAM. MD. 22. Name and Addrass of Facility 21. Signature of Funeral Service Lipphses LIKE MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediate Ceuse (Finel disaase or condition rasulting In daath) MYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE Examiner Dua to (or as a consequence of) Examiner the death certificate be executed physicien end s the buriei-transit Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initieted events resulting in death) Lest Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consaquence of): 80 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ETHANOL ABUSE signed t Records, þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? certificate hes b irector, page 2 s 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: after deeth. Director: After this certifica 25. Wes casa refarred to medical examiner? Be 26. Placa of Daath (Check only one) To examiner? 1 Yas 2 No Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 □Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yas 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Sulcida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 4 Homicida 2 24 hours aft Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and mannar stated. 29a. Certifiar edicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of 29c. Licansa number 29d. Data signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Itam 23a) (Type, Print) DRIVE, CHEVERLY, MARYLAND 20785 3001 HOSPITAL GOLLE MARIO 31. Data filad (Month, Day, Yaar) 32. Registrar's Signetura

DHMH 16 Rav 6/95

State

Registrar

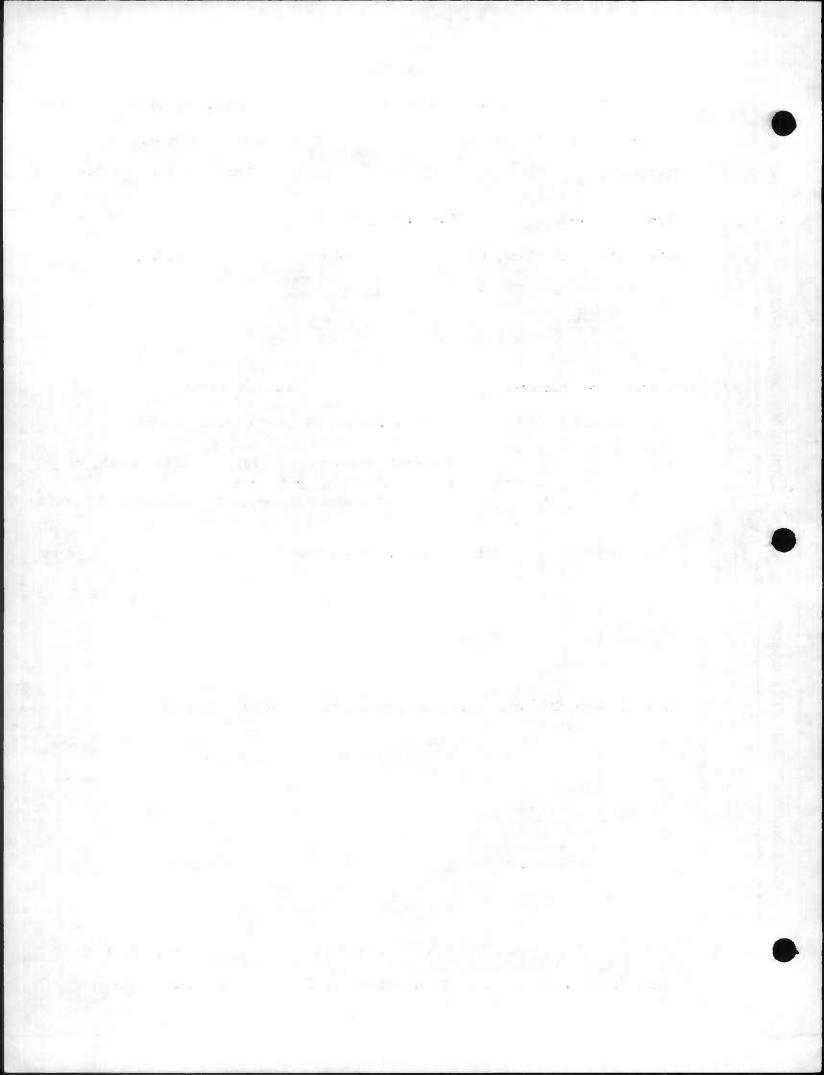
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State of Maryland / Department of Health and Mental Hygiene 9 9 3 1993

				Certifica	ate of	Death		Reg. No.		1220			
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	Manor Care Hea			tat to 1 Million	ler 1 Year	Chevy Cha		Montg					
(. Social Security Number 6. 052-07-6081 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last i	Month		Hours Min	8. Date of Bir (Month, De April 1	Y. Year) 4, 1914	9. Birthpla Country New Y	ace (Stata or Foraig (Y) Ork			
-	0a. Stete 10b. County		10c. City, To	wn or Location					10	d. Inside City Limits			
1	N/A N/A		Wash	ington,	DC					Yes 2 No			
1	0e. Street and Number			101. 2	Cip Code			10g. Citizen of \	What Count	ry?			
	4201 Butterworth	Place, NW	T.		20016	5		U.S.A.					
1	1. Marital Status 1 ☐ Never Merried 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:	Ever in U,S. No		edent of H pecify Cubs 2X No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Blee Specify	e - Amarica ck, White, e	tc.			
	15. Decedent's I		16	a. Decedent's Us	ual Occup	etion during most of work	ina	16b. Kind of B	usiness/Indu	ustry			
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L	12			Tailo	r			Garmer					
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-	4 ☐ Donation 5 ☐ Other (Spec 21. Signeture of Funerel Service Lice	-	Nati	onal Cre			999	Falls C	hurch	, VA			
ľ	N / N / S	11500		JOSE	PH GA	WLER'S S	ONS						
21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility JOSEPH GAWLER'S SONS 5130 Wisconsin Ave., NW Washington, 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.													
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2	5. Wes case referred to medical axaminar?					26. Place of Deel	th (Check only	one)					
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2	7. Magner of Death 1 Neturet 5 Panding 2 Accident investigeti 3 Suicide 6 Could not	De		. Time of Injury M			28d. Describe	how injury occur	red				
	4 Homicide determined	building, et	c. (Specify)	farm, street, fect	ory, omce		City or To	Street and Numb wn, State)	oer or Hurar	House Multiper,			
	29e. Certifier 1 Certifying P (Check only one)	hysician: To the best of miner: On the basis of and manner ste	examinetion (ge, death occurre and/or investigation	on, in my o	ne, date end place, pinion, death occur	end due to the red at the time,	ceuse(s) end me dete end pteca,	and due to	ated the cause(s)			
2	9b. Signetura and title of certifier	/		11 .1 2	9c. Licens	e number		29d. Dete signe	d (Month, D	Pay, Year)			
	usa B.	paperter	w,	Wh. U.]	D3755	5		Sept. 2	9, 19	99			
3	0. Name and eddress of person who	completed cause of d	eath (Item 23s) (Type, Print)									
	Lisa B. Sapper	stein MD,	5410 Cc	nnectic	ut Av	e. NW Was	hington	DC 20	015				
3	1. Dete filed (Month, Day, Year)	32. Registra	ar's Signeture	4 /	and.	,							

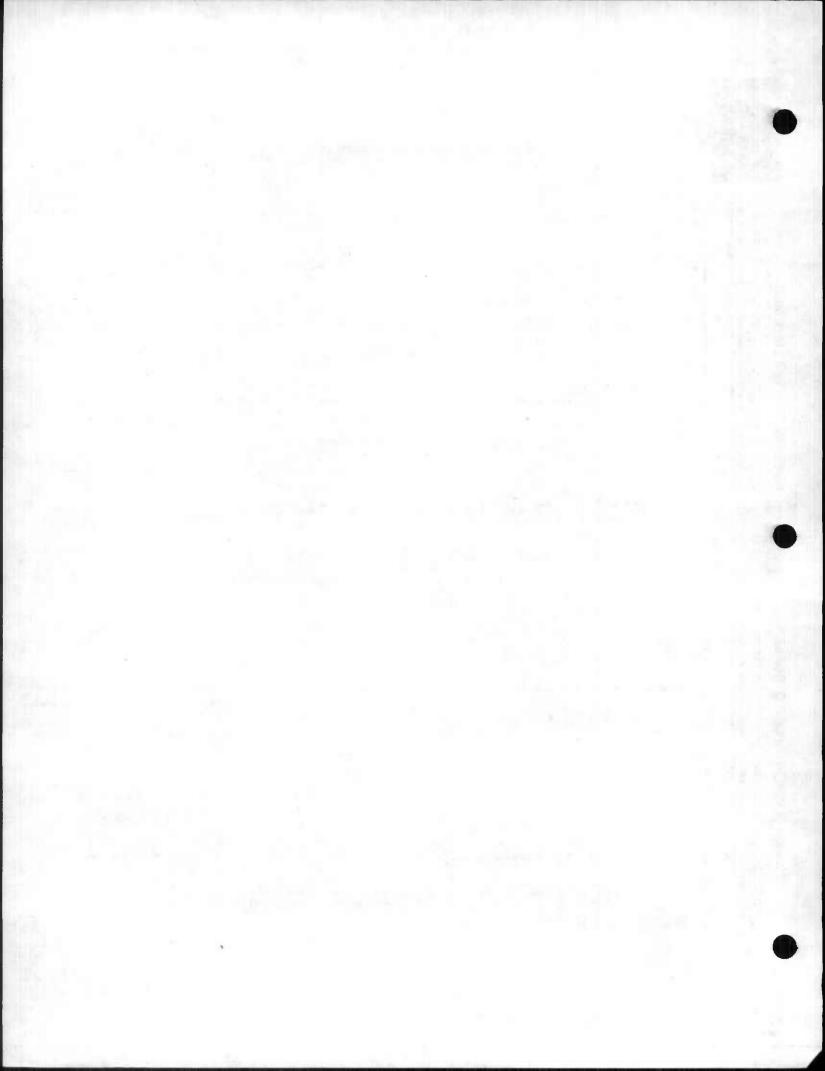


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 22, 1999 7:45PM Physician Joseph P. Capone, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paint Branch Nursing Home Adelphi Prince Georges If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours ₩ 2 F Months Yrs 72 Director 577-30-2443 May 21, 1927 Washington, DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 200-Maryland Montgomery Silver Spring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2305 Ladymeade Dr 20910 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.
Int. If Item 27 is merited other than "natural", or its inversed other than "natural", or its inversed other than "natural". 1 DXYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dental Technician Oral Hygiene Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Phillip Capone Grace Morfast 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joseph P. Capone, Jr./Son 2305 Ladymeade Dr, Silver Spring, MD 20910 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State permit. Page Department of Important: If any injury or otice. 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory | Sept 26 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Hines-Rinaldi Funeral Home Mey 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart lailure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL UNKNOWN INFARCTION Examiner Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Physician/Medical Due to (or as e consequence of) US0 88 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Hinknown ALZHEIMER'S DISEASE þ SEIZURE DISORDER 24b. Were autopsy lindings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed After this cartificate has PARKINSONISM 1 Yes 2 No 1 ∏Yes 2 □No Physician: 25. Was case referred to medicat examiner? Medical Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? s of attending P s effer death. I Director: After to d in by the funeri Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funeral Discompletely filled 1 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23181 5 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) M.D. 704 GORMAN AVE # T-1. LAUREL MD20707 R.G. BHOJRAJ

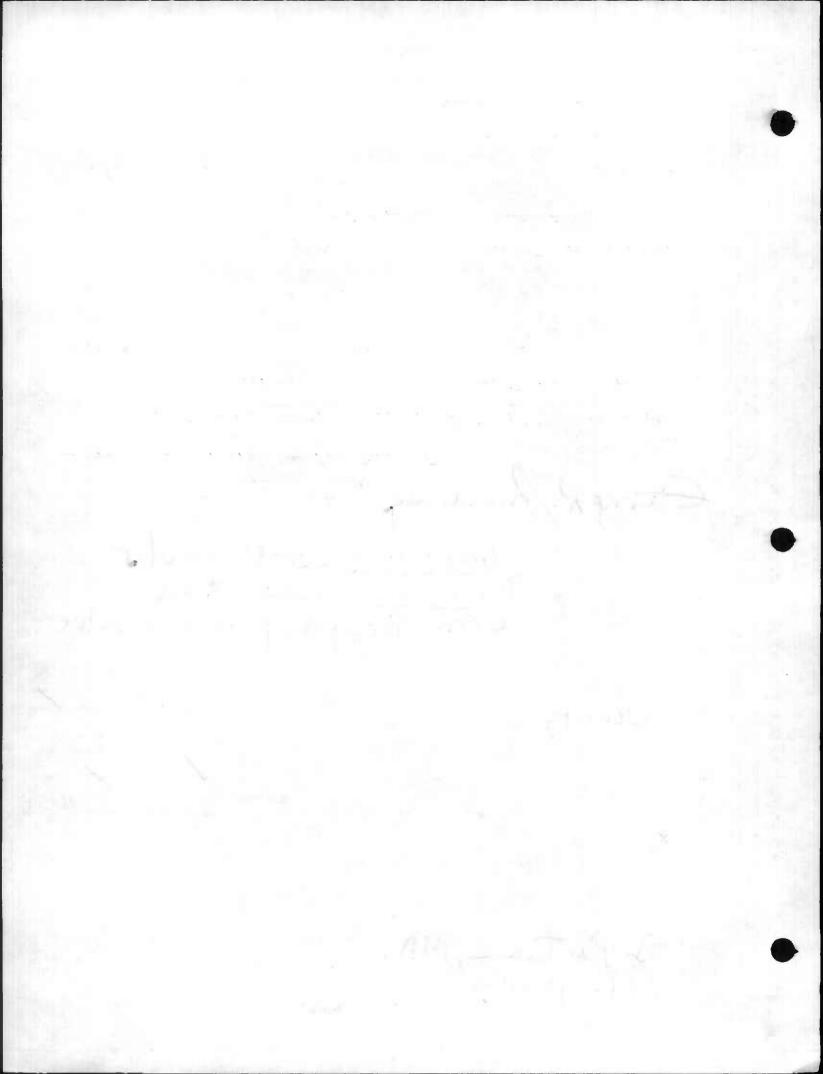
State Registrar 31. Date filed (Month, Day, Year) **SEP 2 8** 1999 32. Flegiskrar's Signeture

9. Sparks



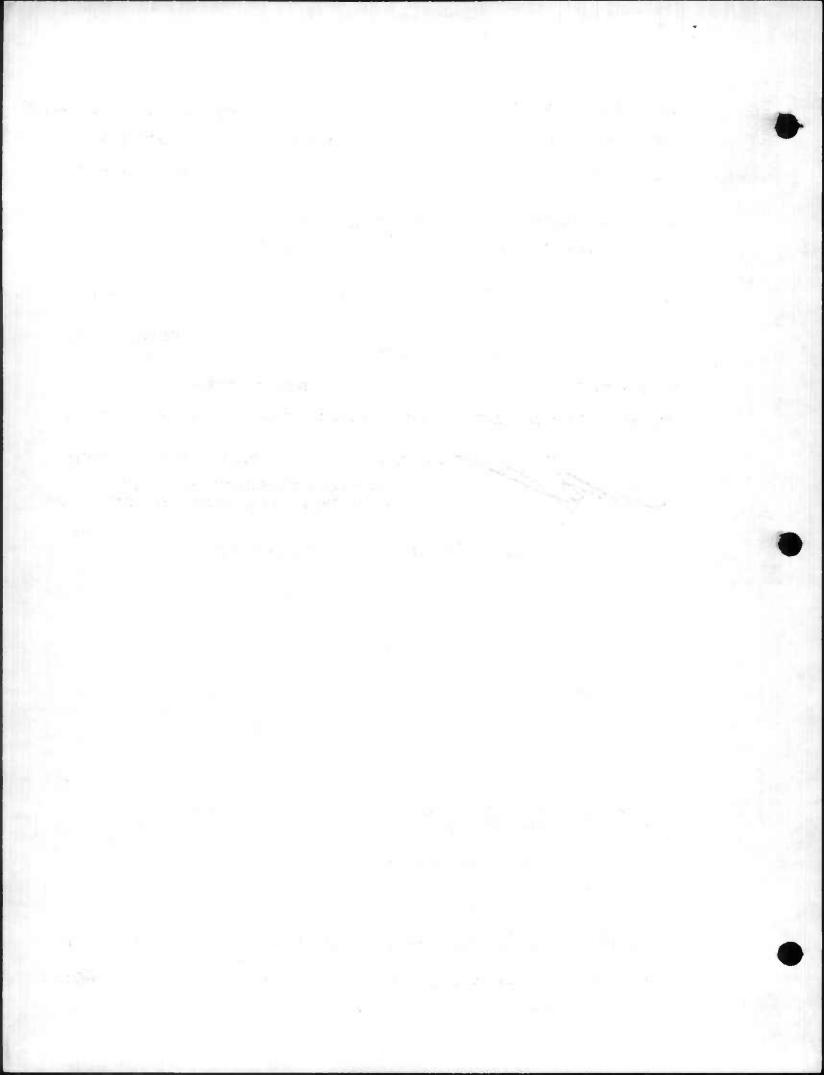
State of Maryland / Department of Health and Mental Hygiene 9 9 9 5

				Ce	ertificate of	Death	Re	eg. No.	0	1990
	Discontation.	1. Decedent's Neme (First, Middle, Last)					2. Dete of Deat Month		Year	3. Time of Death
4	Physician /Medical	DAVID	CHENAULT	, III			SEPTEMBI		1999	1205 PM
	Examiner	4e Facility Neme (If not institution, give :				4b. City, Town, or L	ocation of Death	4c. County of	of Death	
		10011 KENSINGTON				KENSINGTO		MONTO		
ı	Funeral Director	5/8-64-321/	7. Age (In yrs. I	ast birthday Yrs.	Months Deys		8. Dete of Birth (Month, Day, Feb. 14	,1948	9. Birthpi Count Was	ace (State or Foreign try) Sh. DC
	pu &	Usuel Rasidence of Decedent 10a. Stete 10b. County	10c. City	, Town or L	ocation				10	Od. Inside City Limits
	e Maryli Le-f eho Ctor	MD Montgo			sington					1⊠ Yes 2 □ No
	siter deeth with the Marylan or Items 23a or 28a-f show miner must be notified at r Funeral Director	10e. Street and Number 10011 Kensingt	ton Pkwy		10f. Zip Code 2 C	1895	10	0g. Citizen of W U.S		try?
5-0020	E	11. Meritel Stetus 1 ☑ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2X No If Yes, Give Yeer or Detes:	S. 13.	Was Decedent of If Yas, specify Cul 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spoan, Maxican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bleck	- America , Whita, o Bla	
5-0	ed within 72 hours ygjene. or then "neturel", nt, tre Medical En-	15. Decedent's Educ (Specify only highest grede		16a. Dec	edent's Usuel Occu	pation during most of work	ina	16b. Kind of Bus	siness/Ind	lustry
21	within then the months	Elementery/Secondery (0-12)	College (1-4or 5+)	life.	DO NOT use retin	ed)		G 1		
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and	Mentel Hygidarked other arked other artic event, I	17. Father's Neme (First, Middle, Last) David Chenal	ılt, Jr.				a (First, Middle, A lle Wes		"	
Maryland	2 sho and I s m	19a. Informant's Name/Raletionship (Type Lucille Chenau)				et end Number or Rus Sington 1				
re,	s 1 end I Heelth tem 27 other tr	20a. Method of Disposition	20b. Pl	lece of Disc	position (Neme of emetory or other plant			20c. Location - (
altimore	permit. Peges Department of Important: If its any Injury or o	1 Buriel 2 Semetion 3 R 4 Donetion 5 Other (Specify)	emovel from Stete			Srv.	9/30/99	Alexa	ndr	ia,VA
alti	permit. Pege Department of Important: If any Injury or	et: Signature of Funeral Service biosnas	0/1	1 3	Neme end Addr	ess of Fecility EN FUNERA	AT. HOME	. Р. А.		1 2 91
ш	4029ª (TENCE K.	marde	wolk	ROCKVI	LLE, MD	20850			
		23a. Part1. Enter the disease, of compli- shock, or heart favore. List only or	cations that caused the death re cause on each line.	De not er	nter the mode of dy	ing, such es cardiac	or respiretory arre	est,	1	Approximete fntarval Between Onset and Death
	Physician /Medical	Immediete Ceuse (Final	11	1						Onset and Death
	Examiner	diseese or condition resulting In deeth)	Hyper	ten	SIVE	ard	iovas	cuja		
	je je		Diseas	D SOUTH	squence of):	0.5500	30 ti	0.14	1	
	axecuted n and ial-transit Examiner	Sequentially list conditions	Discosi	40-0-0000	IVI Iquenee-of):	23200	1011	CV	- t	
x 68760,	g physicia as the bur Tedical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last		es a conse	3 icus p	id p	almor	iary	Va	lve
Box	at the death cert d by the attending attached for use a Physician/M			h			L cot Blas		1	
0	ed by the datached	Pert II. Other significant conditions con	tributing to death but not resu	illing in the	underlying causa g	iven in Part I.			3 Prot	the cause of death?
٥, ٥	as that igned to be date by P	Ubesity						2010	00110	Aug online
Records,	v requires that the been signed by th should be datache leted by Phys	/					24a. Wes a perform		24b. We	ere autopsy findings allable prior to
900	2 2 2						ponon	/	CO	mpletion of cause death?
R	The lew ate hes page 2						10 Ye	s 2 No	16	Yes 2□ No
Vital	certificate rector, pag	25. Wes case raferred to medical				26. Place of Dea	th (Check only on	a)		
of V	5 0 D	exeminer? XXXes 2□ No	ospitel: 1 Inpatient 2 I	ER/Outpation	ent 3 DOA	ther: 4 Nursing H	ome 5/E/Reside	ence 6 Othe	r (Specif)	y)
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	To the Hospital or Attendit whith 24 hours after deeth. To the Funeral Director: All completely filled in by the tu Medical Certificatic	29e. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowner: On the basis of examinet and menner steted.	vladga, daa ion and/or i	th occurred at tha t nvestigetion, in my	tima, data and place, opinion, deeth occur	, and due to tha corred at the time, do	ause(s) and mar ate end piece, a	ner as st	ated. the cause(s)
	To the comple	29b. Signeture and title of certifier		AN		C.M.E.		9d. Date signed		
		30. Name and address of person who co	mploted causa of daath (Itam	23a) (Type	p, Print)					
		1 Joseph				Baltimore,	Marylan	d 21201		
	State Registrar	31. Date (Month, Dey, Year) \	32. Registrer's Signet	ture &	. Spor	W				
	Hegistial	001 01 12	10		//					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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н	Physici	an	Decedent's Name (First, Mide								2. Date of De Month	eath Day	y Year	3. Time of Death
ā	/Medi		LENA RAINBOW								Sept	28		05:25 AM
Ä	Examir	er	4a. Fecility Name (If not institution			")				4b. City, Town, or			County of Death	
			HOLY CROSS HC 5. Social Security Number	6 Sex		ma /In ura	last birthday	If Linds	er 1 Year	SILVER SE			ONTGOMER	
	Funeral Director		252.50.6226 Usual Residence of Decedent	1 M		9		Months			01.13.	Ÿ.900	GEC	plece (State or Foreign DRGIA
	show	Į.	10a. State 10b. Count				ty, Town or L							10d. Inside City Limits
	the M	Director	MD MONT 10e. Street end Number	GOMER:	Y	S	ILVER							
	23a or	-65	2201 CLOSTON	ROAD :	#507			101. 2	ip Code	20910)	U.	zen of What Cou SA	untry?
0050	72 hours after death with the Maryland natural; or items 23a or 28a-f show diret Expender mat be roulf ad	by Funer	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ WIdowed 4 □ Divorce	ried	Wes Deceden Armed Forces I ☐ Yes 2 If Yes, Give Year or Detes:	?				Hispanic Origin? (Span, Mexicen, Puer Specify:	Specify Yes or No to Ricen, etc.))-	14. Race - Amer Black, White Specify: WF	
21215-0020	d within 72 piene. r than "nat	Completed	15. Decede (Specify only high: Elementary/Secondary (0-12)		on mpleted) College (1-4or 2	5+)	16a. Dece (Give life.	kind of w DO NOT	ork done	during most of wo	rking	DEP	nd of Business/II ARTMENT GOODS	
nd	be filed ntal Hygi of other event,	Be	17. Father's Name (First, Middle	Last)						18. Mother's Na			Sumame)	
<u>Y</u>	should by nd Menta markad	To	WILLIAM RAINE							BESSIE	E "UNKNO	WN"		
, Maryland	2 8 8		19a. Informant's Name/Relation SHIRLEE C. ST			R				t and Number or Re LD CIRCLE				
Baltimore,	Peges 1 and nent of Heatth int: If item 27 iry or other ti		20e. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	3 Ramo	oval from State		Place of Disponentary, cra	matory or	other pla		Date 10.1.99		ocation - City or T	
Balti	permit. Peges Depertment of Important: If it any Injury or c		21. Signature of Funeral Service	Cifensee			E	DWAR	D SA	ess of Facility GEL FUNER				
		-	23a. Part1. Enter the disease, o shock, or heart failure. Lis	complication	ons that cause	d the deat				VILLE PI			E, MARYI	LAND 20852 Approximate
	Physician /Medical Examiner	ner	tmmediate Cause (Final disease or condition resulting in death)	a		-eb		sch	lar	Accid				Interval Between Onset and Death
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ox 68760,	2 0 0	\/Medical	Cause (Disease or Injury that initiated events resulting In death) Last	c		Due to (o	r as a consec	quence of)	:				1	
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	Jing After fune	tion	27. Manner of Death 1 □ Naturat 5 □ Pendi		Ba. Date of tnj (Month, Da	ay Year)	28b. Time o Injury	M	28c. Inju Wo	iryat ork?]Yes 2 □ No	28d. Describe	how injur	y occurred	
Division	or Attan	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	not be	8e. Place of In building, e						28f. Location (City or To			ral Route Number,
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edical C	29a. Certifier 1 Certifyl (Check only one) 2 Medical	Examiner:	n: To the best On the basis o	of examina	wledge, deatl tion and/or in	h occurred vestigation	at the ti	me, date and place opinion, death occu	o, and due to the erred at the time,	ceuse(s) date and	and manner as place, and due	stated. to the ceuse(s)
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	6		> Jeffry	al	érli		w	>	D	47188	3	Ser	tember	29 1999 20852
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	Sta Registr	100	31. Date filed (Month, Day, Year	1000	32. Regist	rar's Signa	ture 4		ha	1/1				



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 40 SEPT 10 V CHERT 29 991 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not Institution, give street and number) 4c. County of Death Examiner SPRING SPRING MANOR CARE SILUE SILVER MON 140MERY If Under 24 Hrs. B. Dete of Birth (Month, Day, Year)

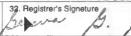
January 5, 1909 If Under 1 Year 5. Sociel Security Number 7. Age (in yrs. last birthday) Birthpiece (State or Foreign Country) 6 Sex **Funeral** Deys 10℃M 2□ F Months 577-60-1770 90 **Director** Russia Usual Residence of Decedent death with the Maryland 10e Stete 10b County 10c. City. Town or Location 10d. fnslde City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at Silver Spring Maryland Montgomery ty Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20901-3352 United States 9039 Sligo Creek Parkway Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 1943–1946 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Meritel Stetus Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours effer teppartment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ther any Injury or other traumatic event, the Medical Examina 1 ☐ Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry U.S. Government Eiementary/Secondary (0-12) College (1-4or 5+) Attorney 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Rebecca Kallick Chertkov Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 9039 Sligo Creek Parkway Silver Spring, MD 20901 Ruth Naomi Chertkov/ Wife 20b. Plece of Disposition (Name of cemetery, crematory or other placa)
Geo. Wash. University Sept.29 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetlon 3 ☐ Removal from State Washington, D.C. 4 Donation 5 Other (Specify) Medical Center
22. Name end Address of Fecility 21. Signature of meral Service Licensee Columbia Mortuary Srvices, Inc. P.O. Box 58007 Washington, D.C. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) Examiner Examiner elemonia physician and s the bunal-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or as e consequenca of): Physician/Medical Due to (or es e consequenca of): el Possible MI 98 nor 10 Pertiff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peed has page 2 1 ☐ Yes 2 ₺ No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician; director. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1 Naturel 5 Pending P Hospital or Attending 24 hours efter death. Funeral Director: Aft 1 Yes investigetion 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.

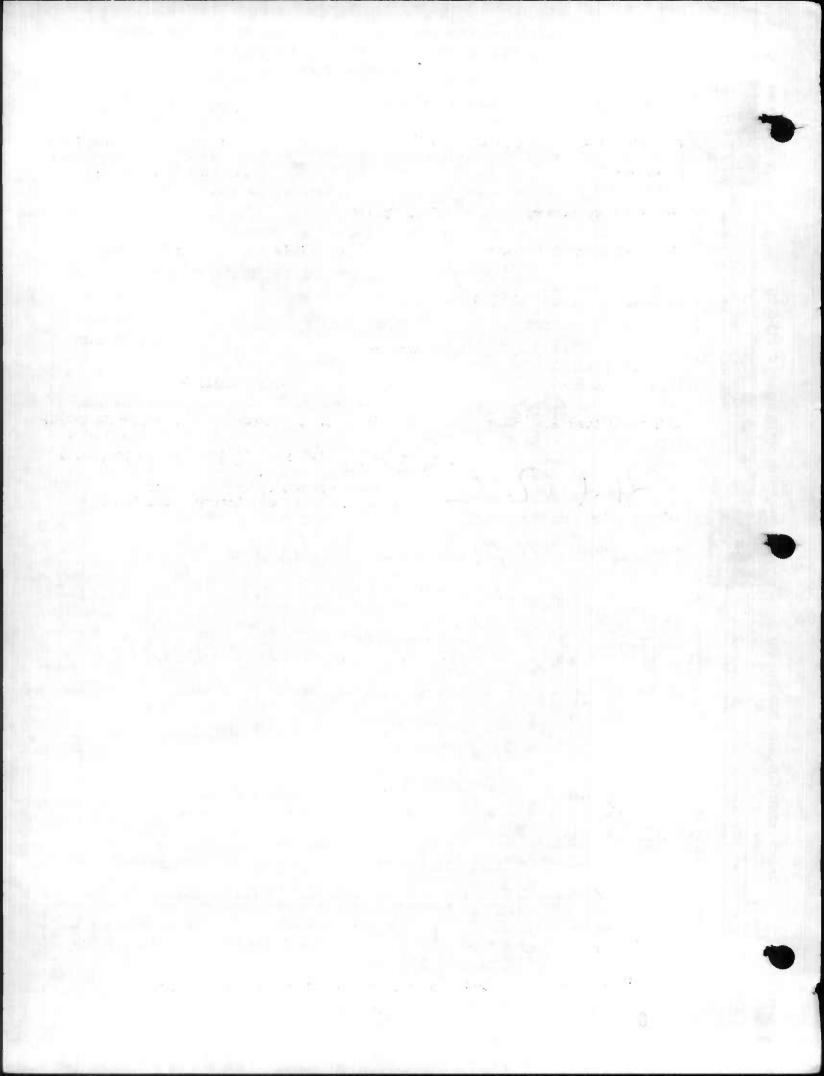
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end menner steted. edicai 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier e. 202 9 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Kirti Vohra 1299 Lamberton Drive Silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year)

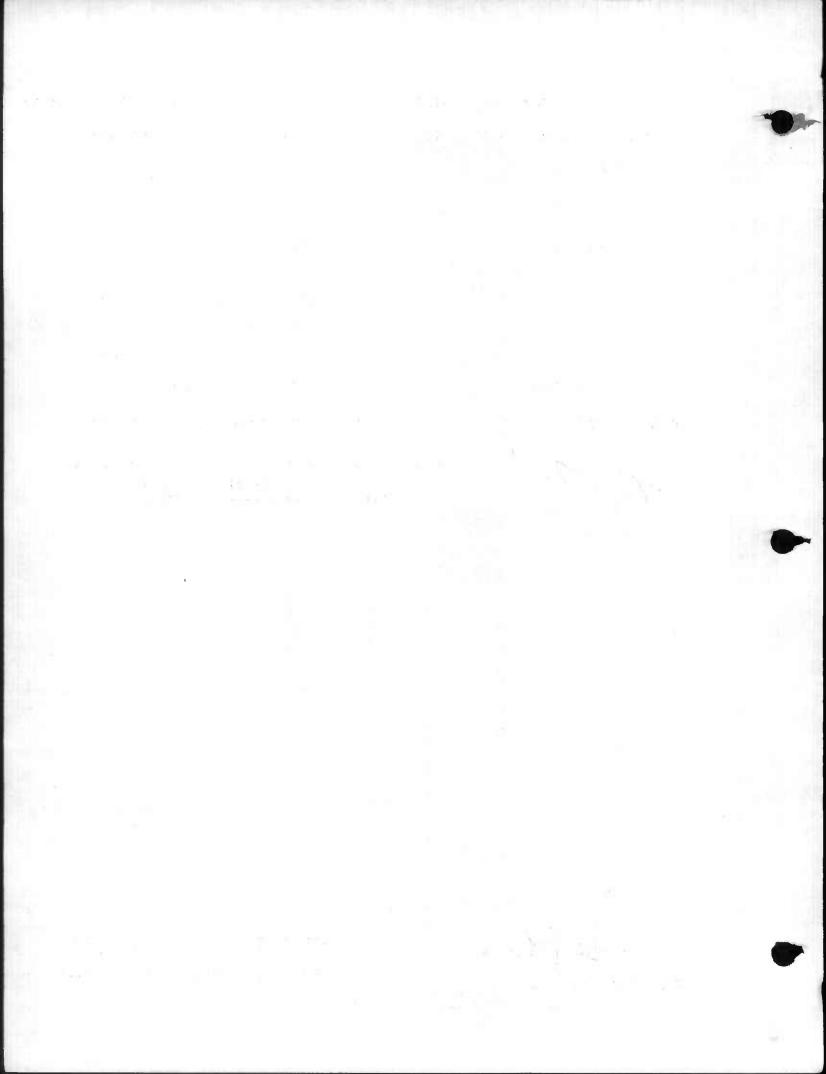
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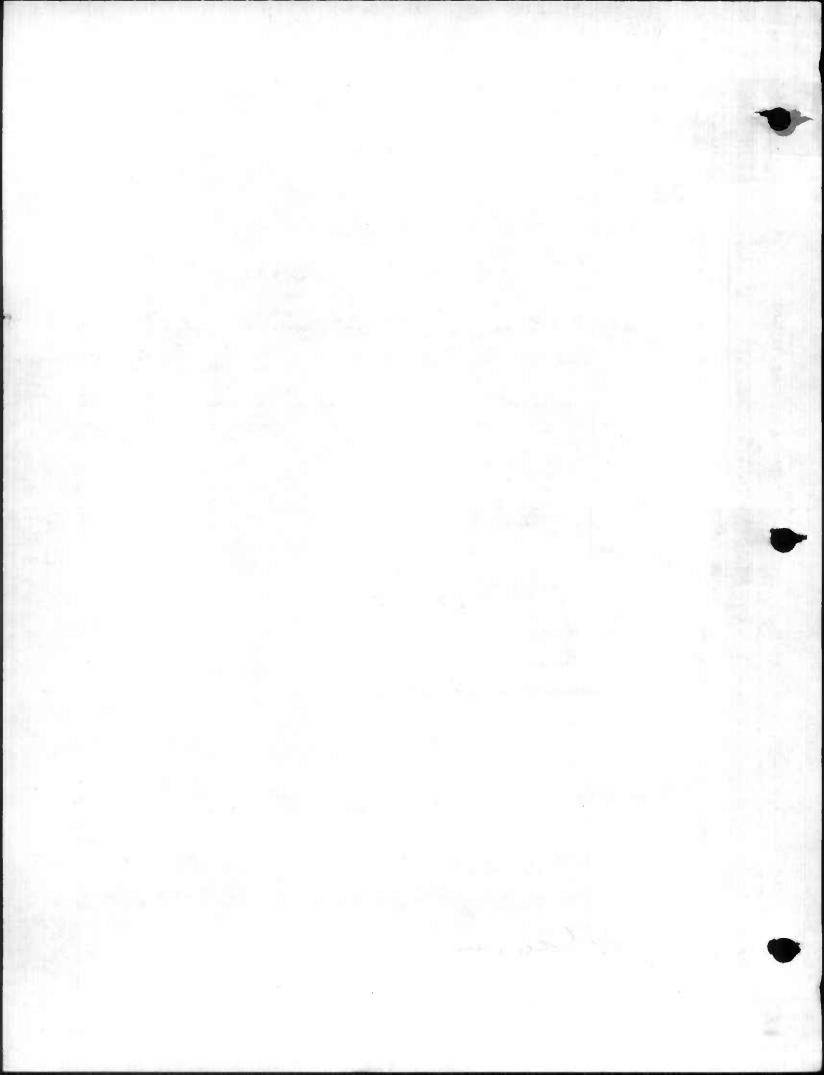


State of Maryland	Depa	rtment	of	Health	and	Mental	Hygiene
	_						

1						Ce	rtificate	e of l	Death			g. No.		31998
10.00	Physici		Decedent's Name (First, Middle, Last VIRGI		CLAY'	TON				2	2. Dete of Deetl Montb SEP	h	9 °9 °9	3. Time of Death 1:45 PM
	/Medic Examir	_	4a. Facility Neme (If not institution, give NATIONAL NAVA			ER		4		wn, or Loce HESDA	ation of Death	4c. County	of Death	
	Funeral Director			9x 7. A □ M 2以 F	ge (In yrs. la 74	st birthday) Yrs.	If Under Months	1 Yeer Days	If Under:	Min.	B. Dete of Birth (Month, Dey, May 10,			elace (State or Foreign htry) h Dakota
	the Maryland	ctor	Usuel Residence of Decedent 10a. Stete VA Fairf	ВX		Town or Lo	ocation						1	0d. Inside City Limits 1 X Yes 2 No
:	th with the	Funeral Director	10e. Street and Number 10021 Ranger Road				10f, Zip	Code	2203	0	10	U.S.A		itry?
020	aftar daa or iteme	by	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 Ki If Yes, Give Yeer or Dates:	?	1	Was Deced If Yes, spec 1 ☐ Yes 2			gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)	Bla	ce - Americ ck, White, y: Cau	
21215-0020	c	mpieted	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)		dent's Usue kind of wor DO NOT us		ation during most ()	of working	7	16b. Kind of B		
ם	a and 2 should be filed within thealth and Mental Hygiene. Item 27 ie marked other than other traumatic event, the M	To Be Completed	12 17. Father's Name (First, Middle, Lest) Samuel C. McLaugh	lin		Bank	Telle	er			First, Middle, N	feiden Suman	ons I	3ank
	tem 27 le ma them 27 le ma other trauma		19a. Informant's Name/Reletionship (7) Gregory Clayton	ype, Print)	001 51	107	Court	land			Route Number,	burg,	VA 22	2407
Baltimore	riment o		20e. Method of Disposition 1)	COL		matory or of	iner plea tion	al Cer		0-6-99	20c. Location		No. VA
BB	Department of the partment of		March				10565	Mai	n St	Fair	rly Fun fax, VA	22030	ome	
	Physician /Medical Examiner	_	Immediate Cause (Finel disease or condition resulting in death)		IC CI		IS	9 Or Oyan	g, such as	cardiac or i	темрическу епте	ist,		Approximate interval Between Onset and Deeth
),	ate be axecuted hysician and tha burlef-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause, (Disease or injury	b	Due to (or	as a consec	quence of):	<u> </u>					 	
687	heam ceruncate be attanding physicis of for usa as tha bu	/Medical	Cause (Disease or injury that initiated events resulting In deeth) Last	d	Due to (or e	es e conseq	uence of):							
P.O.	ne che	by Physician/Med	Part II. Other significant conditions co	ntributing to death b	out not result	ting in the u	nderlying ca	ause give	en in Parti.					the cause of death?
9	has been signed it	Completed b			*						24a. Was ar perform	autopsy ned?	ave	ere autopsy findings eilable prior to mpletion of cause death?
= 5	at a	Be Co	25. Was case referred to medical						26 Plece	of Deeth /	1 ☐ Ye	s 2 No	10	Yes 2□ No
of Vita		ToB	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 E	R/Outpatier	nt 3 DO	A Othe	or.		9 5 ☐ Reside	4	er (Specif	y)
Division of	After		27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be	28e. Date of Inju (Month, De		28b. Time of injury	М			28 No	d. Describe ho	w Injury occur	red	
Divi	를 들는 다음 다음	Certif	4 ☐ Homicide determined	building, et	c. (Specify)						City or Town	, Stete)		l Route Number,
	n 24 hours on Funeral pletely filled	edical	(Check only one) (Check only one) (Check only one)	sician: To the best inar: On the basis o end menner st	exemination	on end/or in	estigation,	in my op	olnion, deet	d piece, an th occurred	d due to the ca let the time, da	use(s) end me te end plece,	and due to	eted. the cause(s)
P	V vithin 2 Comple	2	29b. Signature end title of certifier	-	D.				97-01	873	29	d. Date signe	Month,	Day, Year)
	Sta		30. Neme and address to person who of J.J.SPOSATO, LT 31. Dete filed (Month, Day, Year)	MC, USNR	deeth (Item a		Print)	NAT	IONAL	NAVA	L MEDIC	CAL CEN	TER, I	BETHESDA MI



1. Decedent's Nama (First, Middle, Last)		Certificate	e of Death	100:	Reg. No.	10=11
William St.				2. Date of D Month	Day	Year 3. Time of Deeti
Ralph F. Colross 4a Fecility Name (If not institution, give s	street and number		4h City Town	Septem or Location of Dear	ber 24,	
Mariner Health - Ke 5. Social Security Number 6. Sex		birthday) If Under		rs. 8. Dete of Bi	Montgo	
	IM 2□ F 78	Yrs. Months	Days Hours M	n. (Month, D Dec. 4		9. Birthplace (State or Fore Country)
Usual Residence of Decedent	1.0			Dec. 4	1920 F	ennsylvania
10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Lim
Maryland Montgome	ry Kei	nsington				1 ☐ Yes 2 ☑
10e. Street and Number		10f. Zip	Code		10g. Citizen of W	hat Country?
10408 Ewell Avenue			20895		USA	
	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Deced	ent of Hispanic Origin? Ify Cuban, Mexican, Pu	(Specify Yas or Nerto Rican, etc.)		- American Indian, k, White, etc.
1 Never Married 2 Married	1 ∑Yes 2 No If Yes, Give	1□ Yes 2	El No Specify:		Specify:	
3 Widowed 4 Divorced	Year or Dates: WW II	Davidson's Market			Tack Kind of Do	White
15. Decedent's Educ (Specify only highest grade	ation (completed)	6a. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of v	vorking	16b. Kind of Bu	siness/industry
Elementary/Secondary (0-12)	College (1-4or 5+)				F. J 1	0
17. Father's Name (First, Middle, Last)	5+ A:	rr rrailio	Controlle 18. Mother's N		Federal , Maiden Sumami	Government
	25.5				ntinota	
Ralph Fred Colro		9b. Mailing Address	Juli (Street and Number or			Stete, Zip Code)
Rita B. Colross						
20a. Method of Disposition	20b. Placa	of Disposition (Nam	e of	Date	20c. Location -	and 20895 City or Town, State
1 Burial 2 Cremation 3 Re 4 Donation 5 Dother (Specify)	emovel from State	etery, cremetory or of		0/27/00	Cdlaron	Condon Mourel
21. Signature of Funeral Service License			Address of Fecility	; 3/2//33	SIIVEL	spring, maryia
DOIM +	121)	Francis	J. Collin			
220 Parts Enter the disease or comple	Dyrl	500 Uni	lversity Bl	vd.,W.,S	ilver Sp	ring, MD 2090]
23a. Part1. Enter the disease, or complice shock, or heart feilure. List only one	e cause on each line.	VIOLENIE IN THE THOUSE	or dying, sour es card	iac or respiratory	arraot,	Intervel Between Onset and Death
Immediate Cause (Finel						
disease or condition resulting in death)	Parkinson's D					10 years
	Due to (or as	a consequence of):				
Sequentially list conditions b.	Due to for as	a consequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C.	50010 (0. 85	a consequence ory.				
that initiated events	Due to (or es	e consequence of):				
resulting in death) Last						
d.						
Part II. Other significant conditions conti	tributing to death but not resulting	g in the underlying ca	use given in Pert I.	23b. Dic	I tobacco use con	tribute to the cause of dea
				10	Yes ZO No	3 Probably 4 Unkn
					s en eutopsy ormed?	24b. Were eutopsy finding available prior to
				_		complation of causa of death?
				10	Yas 2√2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of I	1 Death (Check only	574	1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpetient 2 ☐ ER/	Outpatient 3 DO	Other:	Death (Check only	574	
examiner? 1 ☐ Yes 2⊠ No Hx 27. Manner of Death	1 Inpatient 2 I ERV		Other:	Death (Check only	one)	er (Specify)
examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation	1 Inpatient 2 LERV		Other: 4K Nursin	Death (Check only	one) idenca 6 □Othe	er (Specify)
examiner? 1 Yes 2 No 1. Manner of Death 1. Natural 5 Pending	1 Inpatient 2 I ERV	b. Time of Injury M	A Other: 4 Nursing Nur	Death (Check only) J Home 5 Res 28d. Describe	one) iidenca 6 Othe	er (Specify)
examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Placa of Injury - At home,	b. Time of Injury M	A Other: 4 Nursing Nur	Death (Check only) J Home 5 Res 28d. Describe	one) idenca 6 Other how injury occurre	er (Specify) ed
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physic	28a. Date of Injury (Month, Day Year) 28e. Placa of Injury - At home, building, etc. (Specify)	b. Time of Injury M M , farm, street, factory.	A Other: 45 Nursing Sc. Injury at Work? 1 Yes 2 No office	Death (Check only) g Home 5 Res 28d. Describe 28f. Location City or To	one) iidenca 6 Othe how injury occurr (Street and Numberson, State)	er (Specify) ed er or Rural Route Number,
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examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 25b. Signature and tide/of certifier 30. Name and address of person who conditions	28a. Date of Injury (Month, Day Year) 28a. Placa of Injury - At home, building, etc. (Specify) iclan: To the best of my knowled her: On the basis of axamination and manner stated.	b. Time of Injury M 21 21 22 22 22 22 22 22 22 22 22 22 22	A Other: 4K Nursing 3c. Injury at Work? 1 Yes 2 No office at the time, date and plain my opinion, death of License number	Death (Check only) g Home 5 Res 28d. Describe 28f. Location City or To	idenca 6 Other how injury occurry (Street and Number own, Stete) cause(s) and ma, date and place, a 29d. Dete signed	er (Specify) ed er or Rural Route Number, nner as stated. and due to the cause(s) if (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Certifica	ite or	Death		Reg. No.					
Physici /Medic		Decedent's Nema (First, Middle, Last MARGARET	RUTH	С	OONEY				Dete of Deet Month Sept.	h	ġ g r		of Death 04 AN
Examin	ier	4a. Facility Nama (If not institution, give Wilson Health Car					Gait	hersb	urg	. À			
uneral irector		215-09-5697	X 7. Aga	(In yrs. last birth	Month	er 1 Yeer Deys	If Under Hours	Min	Dete of Birth (Month, Day, UNE 21	Year) 1918	9. Birthpl Mary	an c	e or Foreig
a-f show	ctor	Usual Rasidanca of Decedant 10a. Stete 10b. County Maryland Baltimore	re	10c. City, Town Cat	or Location ONSVil	1e					10		City Limi
23a or 28	al Director	10e. Street and Number 715 Maiden Choic	e Lane		10f. 2	ip Coda 2122	28			og. Citizan of N United		•	
ilene. r than "natural", or items 23a or 28a-1 show the Med cal Examiner mast be mutified at	by Funeral	11. Maritel Stetus 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedant E Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yeer or Datas:		13. Wes Dec If Yas, sp	edent of Hecify Cubi	llspanic Ori an, Mexican Specify:		y Yas or No- an, atc.)	Ble	e - Amarica ck, Whita, a V: Whit	itc.	
thgiene. ther then "netural", or items 23s or 28s-1 show ont, the Medical Examiner must be muthed at	Completed by	15, Decedant's Edu (Specify only highast grad Elamantary/Secondary (0-12)	cation a completed) Collega (1-4or 5-	-)	Decedent's Us 'Giva kind of N lifa. DO NOT	ual Occup vork dona use retire	eation during most d)	t of working		16b. Kind of B			t
d othe	To Be Co	17. Fethar's Nama (First, Middla, Last) William Thomas	Cooney,	Sr.	TOTAL		18. Moths		First, Middla, A	Maidan Sumen denbur	ne)		
27 is r trac		19a. Informant's Name/Relationship (7) C. Douglas Coone			Mailing Addra Maide	ss (Straat n Cho	end Number	er or Aural A _ane,	Catons	ville,	Stata, Zip Mary	Code) land	2122
0 H 0	0 3	20a. Method of Disposition 1 ☐ Bunal 2 MCremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Othar (Specify)	Ramovai from State		Disposition (A cremetory of Olitan	othar pla		1		20c. Location - Alexano	,		
Departmen Important: any injury 2009		21. Signature of Funeral Service Udlens	6			1 H.	Barbe 5038	er Fun	eral H tonsvi	ome 11e, Ma	aryla	nd 20	0882
ysician Medical kaminer	er	23a. Party. Enter tha disease, or complished, or haart fallura. List only of Immediate Causa (Final diseasa or condition rasulting In death)	Coror		Arte	1		serdiac or re		est,		Approxim Interval E Onsat an	Batween
nding physicien end use es the buriel-transit	n/Medical Examiner	Sequantially list conditions, if eny, leading to immadiate cause. Entar Undarlying Causa (Disease or Injury that initiated evants resulting In daeth) Lest	3	Due to (or as a co									
by the attend eteched for us	Physician	Part II. Other significant conditions con	ntributing to death but	t not rasulting In	tha undarlying	cause giv	en in Pert I	1.	23b. Did to	becco use co	ntribute to		
s been signed t 2 should be det	Completed by								24a. Was a perform	n eutopsy ned?	cor	ra autops liable pric pletion of leath?	sy finding or to of cause
ate he page	Be Com	25. Was casa raferred to medical					28 Place	of Death //	1 ☐ Ya		1 🗆	Yas 2	.□ No
	0	axaminar? 1 ☐ Yes 2 ☐ No	lospital:	t 2 ER/Out	patient 3 1	Oth	ar			ince 8 🗆 Oth	or /Engeit	0	
er thi	ation: T	27. Mannar of Death 1 Naturel 5 Panding 2 Accidant Invastigation	28a. Deta of injury (Month, Day	/ 28b. Ti		28c. inju		280		ow injury occur		,	
within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification:	3 Sulcida 6 Could not be datarmined	28a. Place of Injur building, atc.	(Specify)					City or Town				umber,
the Fune	Medical	(Check only 2 Medicat Exami	nician: To the best of nar: On the basis of a and mariner stet	axamination and	or Invastigation	n, In my c	pinion, daa	d place, and th occurred	et the time, da	ate end plece,	end dua to	tha caus	
5	-	290. Signature and title of certifier	phi	<u></u>			O 5	18	5	ethesda	nbe	29	,190
		30. Name and eddrass of person who of	Simplated cause of dec	ath (Item 23e) (T	ype, Print)	Geni	acto	WM K	ad, B	ethesdo	a. M	0819	t land

DHMH 16 Rav 6/95

Registrar

